



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:
<a href="#"><u>What is the overall deductible?</u></a>	<p>Accountable Health Partners (AHP): \$1,800/Employee (EE) Only or \$3,600/EE + Family (FAM)</p> <p>For <a href="#">in network providers</a>: \$3,000/ EE Only or \$6,000/ FAM</p> <p>For <a href="#">out-of-network providers</a>: \$4,000/ EE Only or \$8,000/ 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>, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.</p>
<a href="#"><u>Are there services covered before you meet your deductible?</u></a>	Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	<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 preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<a href="#"><u>Are there other deductibles for specific services?</u></a>	No	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<a href="#"><u>What is the out-of-pocket limit for this plan?</u></a>	<p>*Salary &lt; \$72,400: AHP: \$3,500/EE Only or \$7,000/FAM; <a href="#">in network providers</a>: \$6,000/ EE Only or \$11,500/ FAM; <a href="#">out-of-network providers</a>: \$6,750/ EE Only or \$13,500/ FAM</p> <p>*Salary ≥ \$72,400: AHP: \$4,000/EE Only or \$8,000/FAM; <a href="#">in network providers</a>: \$6,500/ 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 \$12,500/ FAM; <a href="#">out-of-network providers</a> : \$6,750/ EE Only or \$13,500/ 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.excellusbcbs.com">www.excellusbcbs.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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.rochester.edu/totalrewards](http://www.rochester.edu/totalrewards).



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	15% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	15% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% <a href="#">coinsurance</a>	35% <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)	15% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.navitus.com">www.navitus.com</a>	Generic drugs	\$15 <a href="#">copay</a> /prescription (retail order) after <a href="#">deductible</a>  \$37.50 <a href="#">copay</a> /prescription (mail order) after <a href="#">deductible</a>	\$15 <a href="#">copay</a> /prescription (retail order) after <a href="#">deductible</a>  \$37.50 <a href="#">copay</a> /prescription (mail order) after <a href="#">deductible</a>	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	20% <a href="#">coinsurance</a> with minimum (min) & maximum (max)/prescription; after <a href="#">deductible</a>  \$35 min & \$80 max	20% <a href="#">coinsurance</a> with minimum (min) & maximum (max)/prescription; after <a href="#">deductible</a>  \$35 min & \$80 max	Not covered	The <a href="#">plan</a> requires pharmacies to dispense generic drugs, when available. If you or your provider

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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)	
If you have outpatient surgery		(retail), \$87.50 min & \$200 max (mail order)	(retail), \$87.50 min & \$200 max (mail order)		chooses a higher cost drug instead of the generic equivalent, you will be required to pay the applicable <u>cost-sharing</u> 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 <u>out-of-pocket limit</u> .
	Non-preferred brand drugs	35% <u>coinsurance</u> ; after <u>deductible</u>  \$70 min & \$160 max (retail), \$175 min & \$400 max (mail order)	35% <u>coinsurance</u> ; after <u>deductible</u>  \$70 min & \$160 max (retail), \$175 min & \$400 max (mail order)	Not covered	All <u>specialty drugs</u> must be obtained from a Designated Pharmacy. Coverage will not be provided for <u>specialty drugs</u> obtained at any other pharmacy. More information about <u>specialty drug coverage</u> is available at: <a href="http://www.navitus.com">www.navitus.com</a> .
	<u>Specialty drugs</u> (Tier 4)	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	Not covered	
If you need immediate medical attention	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	15% <u>coinsurance</u> : ambulatory surgery center; 35% <u>coinsurance</u> : all other facilities	40% <u>coinsurance</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u>	35% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	<u>Emergency room care</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	<u>Emergency room care</u> : No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	
	<u>Urgent care</u>	\$35 copay, after deductible	35% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preadmission</u> is required for <u>out-of-network providers</u> . If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service or \$500, whichever is less.

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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)	
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	15% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services rendered through Behavioral Health Partners (BHP) are provided at no cost once the deductible is met.
	Inpatient services	15% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you are pregnant</b>	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).
	Childbirth/delivery professional services	15% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	15% <a href="#">coinsurance</a>	35% <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 you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	15% <a href="#">coinsurance</a>	35% <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.
	<a href="#">Rehabilitation services</a>	15% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	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>	15% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	15% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	120 days/calender 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>	15% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

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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)	
					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>	15% <a href="#">coinsurance</a>	35% <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.
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](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

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.rochester.edu/totalrewards](http://www.rochester.edu/totalrewards).

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, kwijjigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,800
■ <a href="#">Specialist coinsurance</a>	15%
■ <a href="#">Hospital (facility) coinsurance</a>	15%
■ <a href="#">Other coinsurance</a>	15%

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
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#### In this example, Peg would pay:

##### Cost Sharing

<a href="#">Deductibles</a>	\$1,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,610
<i>What isn't covered</i>	
Limits or exclusions	\$30
<b>The total Peg would pay is</b>	<b>\$3,440</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,800
■ <a href="#">Specialist coinsurance</a>	15%
■ <a href="#">Hospital (facility) coinsurance</a>	15%
■ <a href="#">Other coinsurance</a>	15%

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
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#### In this example, Joe would pay:

##### Cost Sharing

<a href="#">Deductibles</a>	\$1,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$530
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Joe would pay is</b>	<b>\$2,430</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,800
■ <a href="#">Specialist coinsurance</a>	15%
■ <a href="#">Hospital (facility) coinsurance</a>	15%
■ <a href="#">Other coinsurance</a>	15%

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
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#### In this example, Mia would pay:

##### Cost Sharing

<a href="#">Deductibles</a>	\$1,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$150
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$1,960</b>

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