2022 Health Program Guide

A General Overview of the University's Health Care Plan, Prescription Drug Plan, Dental Plans, FSA, HSA, Personal Health Management, and Well-U

TOTAL REWARDS
HUMAN RESOURCES
UNIVERSITY OF ROCHESTER

UNIVERSITY OF ROCHESTER 2022

Health Program Guide

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Contents

Health Program Benefits

Promoting wellness and healthy living continues to be an important focus for the University of Rochester. To support our ongoing commitment, the University offers a benefits package designed to help faculty and staff and Strong Memorial Hospital residents and fellows make good health care decisions that not only help you live better, but also help you better manage health care costs.

The University of Rochester is committed to providing you and your family with a comprehensive and competitive benefits package. In order to meet this commitment and our business goals, we developed this Health Program Guide to highlight the benefits, programs, and services available to you.

Take the time to explore this Guide to learn more about the benefits and services that may help you change your behavior to become more involved in your health and use your benefits as wisely as possible. View the Summary Plan Description (SPD) for additional plan and benefit information; a copy of the SPD and benefit summaries are available online at the Office of Total Rewards website and will be provided free of charge upon request.

Put Your Health First

Take a more active role in your health. Eligible individuals can take the Personal Health Assessment (PHA) and enroll in a lifestyle/condition management program and earn incentives! For more information, contact the Center for Employee Wellness at (585) 275-6810 or by email at urcew@urmc.rochester.edu.

If you have questions about . . .	Contact Your Plan Administrator . . .	
	Excellus BlueCross BlueShield	**Gallagher Benefit Services***
Health Care Plans	1-800-659-2808 or (585) 232-2632 www.excellusbcbs.com/ur	1-844-243-0027 https://clients.garnett-powers.com/pd/rochester/
Vision Benefit	N/A	1-844-243-0027 https://clients.garnett-powers.com/pd/rochester/
Supplemental Vision Benefit	800-877-7195 www.VSP.com	N/A
Accountable Health Partners	1-888-457-7463 Direct: (585) 758-7823 www.ahpnetwork.com	N/A
Prescription Drug Plan	1-800-499-2838 www.excellusbcbs.com/ur	1-844-243-0027 https://clients.garnett-powers.com/pd/rochester/
Dental Plans	Excellus BlueCross BlueShield 1-800-724-1675 www.excellusbcbs.com	1-844-243-0027 https://clients.garnett-powers.com/pd/rochester/
Flexible Spending Accounts (FSAs) • Health Care FSA • Limited Purpose Health Care FSA • Dependent Care FSA	Lifetime Benefits Solutions, Inc. 1-800-327-7130 or (585) 232-2632 Fax (for claims): 1-877-256-7228 www.lifetimebenefitsolutions.com	N/A
Health Savings Account (HSA)	HSA Bank 1-866-471-5940 www.hsabank.com	N/A
General Benefits	Office of Total Rewards (585) 275-2084 totalrewards@rochester.edu www.rochester.edu/totalrewards	

If you have questions about . . .	Contact Your Plan Administrator . . .	
	Excellus BlueCross BlueShield	**Gallagher Benefit Services***
Updating your personal data or using HRMS to enroll online as a new hire	ASK-URHR (585) 275-8747 or ask-urhr@rochester.edu www.rochester.edu/people	
Well-U Program	University Well-U Office (585) 273-5240 www.rochester.edu/well-u	
• Condition Management Coaching • Biometric Screenings • PHA	(585) 275-6810 www.urwell.rochester.edu	
Lifestyle Management Programs	(585) 602-0720 www.urwell.rochester.edu	
Behavioral Health Partners (BHP)	(585) 276-6900 www.bhp.urmc.edu	
UR Medicine EAP	UR Medicine EAP (585) 276-9110 www.urmc.rochester.edu/life-work-eap eap@urmc.rochester.edu	
Long-Term Care (LTC) Insurance	For legacy participants enrolled in the CNA group LTC plan: CNA 1-877-430-5824 www.cna.com/portal/site/groupLTC/ For participants with individual LTC policies through Legacy Services: Legacy Services 1-800-230-3398 custsvc@4groupltci.com http://main.legacyltci.com/	

* *Gallagher Benefit Services administers coverage for Postdocs only.*

Official Plan Information

This Health Program Guide, along with the enrollment materials that you receive every year, are intended to supplement the SPD for the following plans:

Plan Name	Plan #	Plan Year	Type of Plan
Health Care Options Health Care Plans for Faculty and Staff of the University of Rochester and SMH residents and fellows*	517	1/1 to 12/31	Group Health Plan providing medical benefits, vision benefits, Health Care FSA, Limited Purpose FSA, Prescription Drug benefits, Condition Management, Personal Health Assessment (PHA), Lifestyle Management, Behavioral Health Partners, biometric screenings, and flu shots
Dental Care Options Dental Plans for Faculty and Staff of the University of Rochester†	518	1/1 to 12/31	Group Health Plan providing dental benefits
Employee Assistance Program Employee Assistance Plan for Faculty and Staff of the University of Rochester	515	1/1 to 12/31	Group Health Plan providing employee assistance plan benefits
Long-Term Care Long-Term Care Plan for Faculty and Staff of the University of Rochester‡	519	1/1 to 12/31	Group Long-Term Care benefits

* *Postdocs will receive Health and Vision coverage from Garnett-Powers & Associates; they are not eligible for a Flexible Spending Account or to receive services through Behavioral Health Partners. Vision requires a separate election and is provided through a separate insurance policy.*

† *Postdocs will receive Dental coverage through Gallagher Benefit Services.*

‡ *The details of the Long-Term Care plan coverage are not described in this booklet, but rather, in the separate certificate of coverage. Please note that individual LTC policies purchased through Legacy Services are not part of Plan 519 or any other employee benefit plan sponsored by the University.*

Your Guide to Making Enrollment Decisions

Health Care Plans, Prescription Drug Plan, Dental Plans, FSAs, and HSA

Choose and Use Benefits Wisely

You make choices each day that are unique to your work, family needs, and personal interests. Be sure to take time to carefully consider your benefit needs and options before making your elections. Consider the types of services and benefit features you need or want and the amount you can reasonably afford to pay out of pocket for the coverage.

Remember that your role as a responsible health care consumer does not end once you enroll for benefits. Throughout the year, you should take an active role in managing your health by maintaining a healthy lifestyle, choosing Accountable Health Partners or in-network[1] providers when appropriate, evaluating your health care choices when care is needed, and using available resources wisely.

Who Is Eligible for Benefits

Please refer to the SPD and the charts on the following pages outlining your and your dependents' eligibility for the Plans included within this Guide and Appendix B for coverage during leaves of absence.

1 Doctors, hospitals, or other health care facilities that are affiliated with Excellus Blue Cross Blue Shield. When you use a doctor, hospital, or other health care facility that is in-network, your out-of-pocket costs are lower, because these providers have agreed to accept discounted rates in return for your use of their services and because the benefit coinsurance is higher.

Employee Eligibility

Program Options	Active 1199 SEIU & SEIU Local 200 Union*	Active Union (IUOE URPSOA)*	Active Full-Time or Part-Time Non-SEIU Union Faculty/Staff	LTD (Union/ non-Union)	Active Residents/ Fellows	Active Post-Docs	Retirees
EAP for Faculty and Staff of the University of Rochester							
N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes†
Health Care Plans for Faculty and Staff of the University of Rochester							
YOUR PPO Plan	No	Yes‡	Yes‡	Yes with Medicare carve-out§	Yes	No	Non-Medicare-eligible only
YOUR HSA-Eligible Plan							
Gallagher Excellus BluePPO Signature Hybrid Plan for medical		No	No	No	No	Yes	No
Gallagher Aetna Vision Preferred PPO for vision							
VSP Vision Care Plan	Yes	Yes	Yes		Yes	No	Yes¶
Via Benefits Medicare Marketplace Access	No	No	No		No		Yes, if Medicare-eligible
Condition Management		Yes if enrolled in medical	Yes if enrolled in medical	Yes, if enrolled in medical	Yes, if enrolled in medical	Yes, if enrolled in medical	Non-Medicare-eligible enrolled in Medical only
Behavioral Health Partners						No	
Lifestyle Management						Yes, if enrolled in medical	
Flexible Spending Accounts	Yes	Yes	Yes	No	Yes	No	No
Dental Plans for Faculty and Staff of the University of Rochester							
Traditional Dental Assistance Plan	No	Yes	Yes	Yes, if non-SEIU member	Yes	No	Yes, if non-SEIU member
Medallion Dental Plan							
Gallagher MetLife dental PPO for dental		No	No	No	No	Yes	No

* *Individuals covered by collective bargaining agreements receive benefits in accordance with those agreements. Copies of those agreements are available upon written request.*

† *Retirees are eligible for the EAP for only the first 18 months following termination of active employment.*

‡ *Time-As-Reported (TAR), Agency Nurses with Medical and retirees who return to active employment may also be eligible for medical if they satisfy the criteria in the University's Look-Back Measurement Period Guidelines.*

§ *LTD recipients must enroll in Medicare when eligible.*

¶ *Retirees and their dependents are eligible to enroll in plans offered through VSP Direct. These plans are not considered University of Rochester group plans.*

Dependent Eligibility

If you are eligible for coverage for the plan benefits, your dependents will be eligible as follows:

Program Options	Spouse	Domestic Partner	Children*	Domestic Partner Children†	Retiree Spouse‡	Retiree Domestic Partner§	Retiree Children¶
Employee Assistance Plan for Faculty and Staff of the University of Rochester							
N/A	Yes				Yes, for the first 18 months following the employee's retirement		
Health Care Plans for Faculty and Staff of the University of Rochester							
YOUR PPO Plan	Yes				Yes (Non-Medicare-eligible only)		
YOUR HSA-Eligible Plan							
Gallagher Excellus BluePPO Signature Hybrid					No		
VSP Vision Care Plan#					Yes**		
Gallagher Aetna Vision Preferred PPO					No		
Via Benefits Medicare Marketplace Access	No				Yes, if Medicare-eligible		
Condition Management	Yes, if enrolled in medical		No		Non-Medicare-eligible enrolled in medical only		No
Behavioral Health Partners	Yes, if enrolled in medical						
Lifestyle Management	Yes, if enrolled in medical		No				
Flexible Spending Accounts	No						
Dental Plans for Faculty and Staff of the University of Rochester#							
Traditional Dental Assistance Plan	Yes				Yes		
Medallion Dental Plan					Yes		
Gallagher MetLife Dental PPO					No		

* *Children are eligible for medical, dental, and vision coverage through the end of the month in which they turn 26, regardless of access to other health care coverage through their own or a spouse's employment, marital status, or student status. Children who became handicapped prior to age 26 and are dependent on the employee for support are eligible for coverage beyond age 26. Eligibility for Behavioral Health Partners (BHP) includes dependent children of active employees or non-Medicare-eligible retirees who are 18 or older and are enrolled in a University Health Care Plan.*

† *Domestic partner children are eligible for medical, dental, and vision coverage through the end of the month in which they turn 26, regardless of access to other health care coverage through their own or a spouse's employment, marital status, or student status. Children who became handicapped prior to age 26 and are dependent on the employee for support are eligible for coverage beyond age 26. Eligibility for Behavioral Health Partners (BHP) includes dependent children of active employees or non-Medicare-eligible retirees who are 18 or older and are enrolled in a University Health Care Plan.*

‡ *Surviving spouses of retirees are eligible for medical coverage if, at the time of the participant's death, (A) the participant had met the age and service requirements to retire, (B) the participant was retired, and (C) the participant had five or more years of service but had not met the criteria to retire (in which case, the surviving spouse/domestic partner and eligible children remain eligible to continue coverage under a health care plan for one year following the participant's death. Following the one year of coverage, these individuals may be offered COBRA for up to 36 months). Surviving spouses are eligible for dental continuation coverage under COBRA following the retiree's death.*

§ *Surviving domestic partners of retirees are eligible for medical coverage if, at the time of the participant's death, (A) the participant had met the age and service requirements to retire, (B) the participant was retired, and (C) the participant had five or more years of service but had not met the criteria to retire (in which case, the surviving spouse/domestic partner and eligible children remain eligible to continue coverage under a health care plan for one year following the participant's death. Following the one year of coverage, these individuals may be offered COBRA for up to 36 months). Surviving spouses are eligible for dental continuation coverage under COBRA following the retiree's death.*

¶ *Surviving children of retirees are eligible for medical coverage if, at the time of the participant's death, (A) the participant had met the age and service requirements to retire, (B) the participant was retired, and (C) the participant had five or more years of service but had not met the criteria to retire (in which case, the surviving spouse/domestic partner and eligible children remain eligible to continue coverage under a health care plan for one year following the participant's death. Following the one year of coverage, these individuals may be offered COBRA for up to 36 months.) Children are eligible for medical, dental, and vision coverage through the end of the month in which they turn 26, regardless of access to other health care coverage through their own or a spouse's employment, marital status, or student status. Children who became handicapped prior to age 26 and are dependent on the employee for support are eligible for coverage beyond age 26. Eligibility for Behavioral Health Partners (BHP) includes dependent children of active employees or non-Medicare-eligible retirees who are 18 or older and are enrolled in a University Health Care Plan.*

\# *Dental and VSP vision plan coverage ends upon the death of the active employee/retiree. Eligible surviving dependents will be offered 36 months of COBRA continuation coverage in the Dental and Vision Plans.*

** *Retirees and their dependents are eligible to enroll in plans offered through VSP Direct. These plans are not considered University of Rochester group plans*

Eligibility Definitions

Active Union (1199 SEIU, SEIU Local200, IUOE, URPSOA)—means an employee of the University whose employment and benefit eligibility is governed by the terms of a collective bargaining agreement entered into between the University and a bargaining unit.

Active Full-Time—means, for hourly staff (excluding those professional, administrative, and supervisory paid hourly): a regular[2] weekly work schedule of at least 35 hours; for all professional, administrative, and supervisory staff: a weekly work schedule of 40 hours or more; for faculty: a normal full teaching and research load as defined for the faculty by the college or school concerned.

Active Part-Time—means a regular[2] weekly or monthly schedule which is less than that required for full-time status but not less than 17.5 hours per week in the case of hourly and professional, administrative, and supervisory staff. For faculty it indicates that the individual carries at least half the normal (full) teaching and research load as defined for faculty by the college or school concerned.

Active Residents/Fellows—means an individual who is classified as a full-time resident or fellow through the University, holds a degree of Doctor of Medicine, and is a member or eligible for membership of the AMA.

Active Post-Docs—means an individual with a Postdoctoral Appointment involving substantial full-time research or scholarship. It is a transitional position and is viewed as preparatory for an academic and/or research career. The appointee is not part of a clinical training program. The appointee was recently awarded the PhD or equivalent doctorate, works under the supervision of a faculty member, and has the freedom and is expected to publish the results of his/her research or scholarship during the period of the appointment.

Appointment—means the action which begins a relationship with the University in a specific position, such as member of the faculty; the period during which such a relationship is in effect.

Children—means an employee's biological or legally adopted children, in addition to stepchildren and children who are placed with the employee by an authorized placement agency or by judgement, decree, or other order of any court of competent jurisdiction.

Continuous Employment—means actively at work in a position eligible for the full range of University Benefit Plans. Absences due to leave of absence or layoff would be included in determining continuous employment.

Domestic Partner—means the same or opposite gender partner of an employee, who, together with the employee, satisfies all of the following criteria:

- Have an exclusive mutual commitment, similar to that of marriage;
- Are each other's sole domestic partner and intend to remain so indefinitely;
- Are not legally married to each other or to anyone else in a marriage recognized by state or federal law;
- Are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which the partners legally reside;
- Are at least 18 years of age and are legally competent to contract;
- Are currently residing together and have resided together in a common household for at least six consecutive months and intend to reside together indefinitely;
- At least six months have elapsed since the Office of Total Rewards has received a Statement of Termination of Domestic Partnership from either partner; and
- Share joint responsibility for the partners' common welfare and financial obligations demonstrated by: (a) the existence of a domestic partner agreement filed through the City of Rochester or another local municipality (a qualifying domestic partnership agreement is a legally binding agreement between two individuals creating personal and financial interdependence, i.e., joint and several liability for each other's debts and expenses, responsibility for mutual care, etc.); and (b) at least two other items showing joint responsibility, such as joint bank accounts, joint deed, mortgage agreement or lease, joint credit account or other liability, joint ownership of a motor vehicle, designation of domestic partner as primary beneficiary for life insurance or retirement contract(s), designation of domestic partner as primary beneficiary of will, durable property or health care power of attorney, co-parenting agreement, or an adoption agreement.

Please note: You will have imputed income and be taxed on the value of your domestic partner's and/or your domestic partner's children's health/dental coverage paid by the University if they do not qualify as your federal tax dependents. Additionally, you will need to pay for premiums for these individuals on an after-tax basis. If your domestic partner and/or his/her dependent children qualify as your tax dependents under federal tax law, you should complete the Affidavit of Domestic Partner's Federal Tax Dependent Status

2 "Regular" means a period of appointment in hourly and professional, administrative, and supervisory positions that is expected to exceed four months, unless otherwise defined in collective bargaining agreements; period of appointment for faculty-instructional staff that is at least one year (or one academic year) or, if shorter, is expected to be renewed. Appointments primarily for furthering education (for example, graduate assistant) are not considered "regular" appointments.

for University Health Benefit Plans. The University encourages you to get advice from a tax professional regarding whether your domestic partner and/or his/her children are your tax dependents and qualify for pre-tax benefits prior to completing this affidavit. If they do not qualify, you do not need to complete the form.

Hired—means, for purposes of determining post-retirement benefits, an appointment to a position that is eligible for the full range of University Benefit Plans.

LTD Employee—means an eligible faculty or staff employee who (1) is receiving long-term disability benefits from the University, (2) is Medicare-eligible, and (3) has enrolled in Medicare Parts A and B as of his/her Medicare-eligibility effective date. For purposes of University medical benefits, Medicare will be the primary payer.

Rehired—means, for purposes of determining post-retirement benefits, "an appointment to a position that is eligible for the full-range of University Benefit Plans from an appointment that was not eligible for the full range of University Benefit Plans or following termination or retirement.

Retiree—means, for University retired faculty and staff members:

- Regular full-time and part-time faculty and staff who were hired or rehired prior to 1/1/96 and who have retired with University consent and (1) who have reached age 55 and (2) who have met the 15-year service requirement. (The 15-year service requirement may be met by cumulative employment at the University or another higher education institution.)
- Regular full-time and part-time faculty and staff who were hired or rehired 1/1/96 and thereafter and who have retired with University consent and (1) who have reached age 60, and (2) who have met the 15-year service requirement. (The 15-year service requirement may be met by cumulative employment at the University or another higher education institution, as long as there is continuous employment at the University for the immediate five years prior to retirement. An employee approaching retirement who meets previous service requirements, during a transition period (1/1/2021–12/31/2023), will have the opportunity to secure benefits under the new model.

Retirement—means an employee has ended employment or an appointment (whether voluntary or involuntary) at normal retirement age or beyond after having met the 15-year service requirement, or:

- For regular full-time and part-time faculty and staff hired or rehired prior to 1/1/96 at an earlier age if the individual has reached age 55 and has met the 15-year service requirement and maintained continuous benefits-eligible service since. (The 15-year service requirement may be met by cumulative employment at the University or another higher education institution.)
- For regular full-time and part-time faculty and staff hired or rehired 1/1/96 and thereafter at an earlier age if the individual has reached age 60 and has met the 15-year service requirement. (The 15-year service requirement may be met by cumulative employment at the University or another higher education institution, as long as there is continuous employment at the University for the immediate five years prior to retirement. An employee approaching retirement who meets previous service requirements, during a transition period (1/1/2021–12/31/2023), will have the opportunity to secure benefits under the new model.

Once retired, Post-Retirement Benefits continue to be based on status and years of service at the time of initial retirement, even if the Retiree returns to work. Retirees will receive the full University subsidy contribution at 15 years versus previous prorated contributions based on years of service. Employees can retire at a part-time status and receive the full-time contribution if they cumulatively meet the full-time equivalent service requirement. There is no adjustment to the Grandparent Level, years of service, or age calculation to determine the level of Post-Retirement benefits based upon Post-Retirement Rehire and employment. However, in the event a Retiree returns to work and becomes eligible for Health Care Plan coverage, Dental Plan coverage, and/or University-paid Basic Term Life insurance coverage because the Retiree has satisfied the eligibility criteria for active employees to participate, the Retiree will be limited to the active employee options and will become ineligible for the post-retirement benefit options.

TAR (Time-As-Reported)—means an appointment with (1) no regular schedule, or (2) in which the individual is expected to work fewer than 17.5 hours per week in the case of hourly and professional, administrative, and supervisory staff, unless otherwise defined in collective bargaining agreements. For faculty it indicates that the individual carries less than half the normal (full) teaching and research load as defined for faculty by the college or school concerned.

Termination—means an ending of appointment for reason other than retirement.

Spouse—means the employee's current spouse, if the marriage was valid in the state or country where it was performed.

How to Enroll: New Hires and Newly Eligible Faculty and Staff

Health Care Plans, Prescription Drug Plan, Dental Plans, Vision Plan, FSAs, and HSA

Enrolling for benefits is easy. The following checklist takes you through the steps you need to complete to elect your Health Program options for 2022.

All required forms are available at the Office of Total Rewards or online at www.rochester.edu/totalrewards/forms.

Individuals covered by collective bargaining agreements receive benefits in accordance with those agreements. Copies of those agreements are available upon written request.

1. Review this Guide.

Carefully read this Guide and the other information provided to you to understand all of the Health Program option(s) available to you and your dependents.

2. Review the Health Plans Comparison Chart.

The chart compares the YOUR PPO Plan and the YOUR HSA-Eligible Plan. It also shows how services are covered under each of the Plans.

3. Learn about the Plans.

Read the benefit booklet from Excellus BlueCross BlueShield to understand how the Plans work. Read the Summaries of Benefits and Coverage for additional information. These can be obtained by contacting the Office of Total Rewards or online on the Office of Human Resources website.

4. Utilize the Online Benefits Decision Tool.

ALEX is an online benefits decision tool that will help you understand the various benefit options and empower you to make informed decisions when it comes to making your benefit elections.

5. Enroll for Benefits.

If you are a new hire and are enrolling for the first time, you can enroll for benefits online using HRMS within 30 days of your hire date. To enroll online, log on to HRMS at www.rochester.edu/people. Select Main Menu, Self-Service, then Benefits, and then Benefits Enrollment.

Understanding your Benefit Administrators

The University of Rochester has partnered with Excellus BlueCross BlueShield to be the third-party administrator (TPA) for our health care plans. TPAs are responsible for processing medical insurance claims from doctors, hospitals, and pharmacies, in addition to helping your health plan stay in compliance with federal regulations.

Additionally, your Health Savings Account (HSA) administrator is HSA Bank, and your Flexible Spending Account (FSA) and COBRA administrator is Lifetime Benefits Solutions.

If you do not wish to enroll online,

- download the enrollment form at www.rochester.edu/totalrewards/health (go to Forms and resources), or
- contact the Office of Total Rewards for the enrollment form by calling (585) 275-2084 or emailing totalrewards@rochester.edu.
- Submit the completed form via email to totalrewards@rochester.edu

Retiree health coverage is maintained through University health plans until age 65. At that time, it is your responsibility to enroll in Medicare. You will be contacted in advance of your 65th birthday by ViaBenefits to discuss transition of plans.

Changing Your Benefits

Health Care Plans, Prescription Drug Plan, Dental Plans, FSAs, and HSA

Can I Enroll at Another Time?

Annual Open Enrollment is the primary time you can enroll or make changes to your Health Care Plan options, Dental Plan, and FSA contributions. Outside of Open Enrollment, you can only enroll in or change your Health Care Plan options, Dental Plan options, Vision Plan options, and FSA contributions or add/remove eligible dependents to/from your Health Care Plan and/or Dental Plan, if you have a corresponding qualifying event or a HIPAA special enrollment period.

Qualifying Event Enrollment Period Changes

Additional qualifying events are provided in Appendix A, but common qualifying events include:

- Change in legal marital status (marriage, divorce, death of spouse, or annulment)
- Change in number of dependents (birth, adoption, placement for adoption, or death)
- Change in your employment status (that affects your benefit eligibility) or that of your spouse or dependent
- Dependent satisfying (or ceasing to satisfy) eligibility requirements for coverage (reaching the age at which coverage is no longer available, etc.)
- Change in cost of day care coverage, such as a significant increase or decrease in costs charged by your current day care provider or a change in your provider (this applies to the Dependent Care FSA only).

Any changes you make must be "due to and consistent with" your qualifying event. The Plan Administrator will determine whether a requested change is due to and consistent with a qualified change in status.

The consistency requirements vary depending on the type of qualifying event. To satisfy the "consistency rule" for certain qualifying events, including those events listed above, your qualified change in status and corresponding change in coverage also must meet both of the following requirements:

- **Effect on eligibility.** Except for the Dependent Care FSA, the qualified change in status must affect eligibility for coverage under the Plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage, or if the qualified change in status results in an increase or decrease in the number of your dependents who may benefit from coverage under the plan.
  For the Dependent Care FSA, the qualified change in status must affect the amount of dependent care expenses eligible for reimbursement. For example, if your child reaches age 13, his or her dependent care expenses are no longer eligible for reimbursement.
- **Corresponding election change.** The election change must correspond with the qualified change in status. For example, if your dependent loses eligibility for coverage under the terms of the University Health Care Plan, you may cancel Health Care Plan coverage only for the dependent that lost eligibility. Additionally, you may change or begin contributions to your Health Care or Dependent Care FSA if you have or adopt a child.

Note: When changing due to a qualifying event, your FSA annual election cannot be reduced below the amount of payroll contributions already deducted or claims already submitted for the calendar year if it would result in a negative balance and the change must be consistent with the qualifying event.

Depending on the circumstances, you may also be able to make changes throughout the year for the following reasons:

- Court judgment, decree, or order to provide coverage to a dependent
- COBRA events
- An eligible dependent drops his or her coverage from another employer's plan during an open enrollment period which is different than that of the University's
- Commencement or return from FMLA leave
- Loss of Medicaid entitlement by you, your spouse, or dependent

As noted, additional qualifying events are provided in Appendix A, but you should contact the Office of Total Rewards if you have any questions regarding qualifying events.

HIPAA Special Enrollment Period Changes

If you are declining enrollment in the plan for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if:

- you or your dependents lose eligibility for that other coverage, or
- an employer stops contributing toward the cost of your or your dependents' other coverage; or
- you or your eligible dependents exhaust COBRA coverage.

However, you must request enrollment within 60 days after your or your dependents' other coverage or COBRA ends (or after the employer stops contributing toward the other coverage).

In addition, you can request (within 60 days) to enroll in the plan or enroll your eligible dependents if:

- you marry, or
- you gain a new dependent because of birth, adoption or placement for adoption.

You can also request (within 60 days) to enroll in the plan or enroll your eligible dependents if you or your eligible dependent:

- loses Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- become eligible for a state's premium assistance program under Medicaid or CHIP.

To request special enrollment or obtain more information, contact the Office of Total Rewards at (585) 275-2084 or email totalrewards@rochester.edu.

Questions

- Call Ask-URHR at (585) 275-8747 or email ask-urhr@UR.Rochester.edu if you have questions about enrolling through HRMS.
- Call the Office of Total Rewards at (585) 275-2084 or email totalrewards@rochester.edu if you have questions about your benefit plans.

Enrollment Form

Your enrollment form must be received by the Office of Total Rewards within 30 days of when you are hired or becoming newly eligible for benefits. Benefit enrollment forms received after 30 days may result in no coverage until the next Open Enrollment or until you experience a qualifying event. (Please refer to Appendix A for when you can make benefit changes outside of Open Enrollment. All qualifying events require supporting documentation and a filled out enrollment form to the Office of Total Rewards within 60 days of the event.)

How to Change Your Coverage

If you need to change your coverage because of a qualifying event, you will need to complete a Qualifying Event Change form and return the completed form along with documentation to support your qualifying event to the Office of Total Rewards within 60 days of the event. Effective date of coverage will generally coincide with the qualifying event date. Employees are responsible for any missed deductions due to their qualifying event date, in the next available payroll. If you are currently covering a domestic partner and get married, within 60 days of the date of the marriage you must submit the Personal Data Change Form and the Qualifying Event Form to update your spouse's relationship designation and avoid taxation issues related to health and/or dental premium deductions. See Appendix A for more information regarding permitted election changes and when they are effective.

Failure to Enroll

If you do not enroll during the initial enrollment period, your Health Program coverage will be defaulted to:

- Waived (No coverage) for Health Care Plan
- Waived (No coverage) for Dental Plan
- Waived (No coverage) for VSP Vision Care
- Waived (No contributions) for Health Care, Limited Purpose and Dependent Care FSA

If you do not make coverage changes during the annual open enrollment period:

- Medical, Dental, and Vision Plan elections will continue
- Enrollment in Health Care, Limited Purpose, and/or Dependent Care FSAs will be discontinued as of the first of the year

Limitations

- If you terminate coverage under the YOUR HSA-Eligible Plan as the result of a qualifying event, any contributions to your HSA via payroll deduction will stop on the effective date.
- If you enroll for coverage under the YOUR HSA-Eligible Plan as the result of a qualifying event, you may be eligible to contribute to a Limited Purpose Health Care FSA and an HSA; however, the HSA contribution maximums are prorated if you will be covered by the YOUR HSA-Eligible Plan for less than 12 months within the calendar year.
- If you are already enrolled in the Health Care FSA, you cannot enroll in a Limited Purpose FSA and HSA until the next Open Enrollment.

An Integrated Approach

When it comes to the health and wellness of our employees and their families, we offer a wide array of programs and services to help you prevent or manage health issues affecting your life. Becoming healthier not only reduces risk for disease and helps us live longer, it also helps us live better.

The University is committed to promoting a culture of wellness. We offer opportunities for you to improve your health, ranging from on-site biometric screenings, a Personal Health Assessment (PHA), lifestyle and condition management programs, indoor walking routes, a program to reward healthy eating, and more choices for faculty and staff to lead happier, healthier lives.

Make a commitment to yourself and your family to become healthier. You can become a Well-U champion and promote wellness within your department.

It is up to you to take the steps to better health, but you do not have to do it alone. The University provides the support, tools, and resources to help you achieve your health goals.

Steps to Take Charge of Your Health

Educate yourself about available health programs and become a confident, active consumer. Use your health care dollars effectively and make informed decisions about what care you need.

1. Complete your biometric screening and online health survey
2. Enroll in a lifestyle management program
3. Enroll in condition management coaching (if eligible)
4. Participate in Well-U programs and events
5. Utilize UR Medicine EAP and Behavioral Health Partners
6. Review your Health Care Plan and Prescription drug options
7. Review your annual wellness catalog

Behavioral Health Partners (BHP)[3]

BHP offers a range of outpatient mental health services, including individual therapies and medication consultation and management. Regular full-time and part-time faculty and staff and SMH residents and fellows age 18 and older enrolled in a University Health Care Plan, as well as non-Medicare-eligible retirees enrolled in a University Health Care Plan, may be eligible. Spouses, domestic partners, and dependent children of active employees or non-Medicare-eligible retirees who are age 18 and older and enrolled in a University Health Care Plan may also be eligible. BHP does not provide pediatric services, and, therefore, enrolled individuals under age 18 are not eligible for BHP benefits.

The cost of BHP services for University employees and dependents (age 18 and older) enrolled in a University health care plan:

- YOUR PPO Plan: Services received through BHP are not subject to the annual deductible and are covered at 100% by the Plan (i.e., there is no out-of-pocket cost).

3 Postdocs are not eligible

Learn about the University's Wellness Programs

Check out the University's employee wellness program, Well-U.

Participate in Well-U Programs

Through Well-U, you may have the opportunity to participate in valuable programs, including:

- Departmental wellness challenges
- University-wide fitness challenges
- Wellness workshops
- Learn to run
- Stress management workshops
- Fitness classes

These programs are available virtually and at numerous locations throughout the University and at off-site locations, making it convenient for you to participate.

The Well-U Mission

Well-U, our award-winning wellness program, can help improve the health and wellness of University faculty and staff and SMH residents and fellows by promoting a work environment that encourages healthy behaviors and by providing the tools, resources, and education necessary to support healthy living.

For more information, go to www.rochester.edu/well-u, call (585) 273-5240, or email well-u-info@rochester.edu.

- YOUR HSA-Eligible Plan: Per IRS regulations, services received through BHP are subject to the annual deductible and are covered at 100% after the annual deductible is met.

BHP mental health professionals include psychologists, social workers, mental health therapists, psychiatrists, and psychiatric nurse practitioners who work together in a multidisciplinary team. BHP providers also work closely with primary care providers to understand and treat the mental health needs of those served.

BHP is a general psychiatry outpatient practice providing outpatient psychotherapy and pharmacotherapy services for persons with a primary mental health condition such as:

- Stress
- Depression
- Anxiety

Not all types of behavioral health services are covered through BHP. An initial appointment with a BHP clinician will help determine if services through BHP are right for you. Some individuals are better served with acute care or subspecialty services that are not available through BHP. BHP does not offer treatment for the following:

- A primary diagnosis of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine, or nicotine use
- Detoxification, chemical dependency, and/or rehabilitation services for alcoholism or substance dependence disorders
- Conditions for which subspecialty care is indicated due to the severity of the mental health symptoms or the need for an alternative treatment setting

Other psychotic diagnosis not listed above and psychiatric emergency, inpatient treatment, or suicide attempt in the past six months.

BHP offers telehealth therapy services. To qualify for telehealth therapy, recipients must be registered patients in BHP. The patient must provide written consent prior to the telehealth services being rendered, acknowledging that the service will be considered an evaluation and management service by the practitioner. Telehealth therapy procedures are as follows:

- The initial service, if appropriate, will be provided in a face-to-face visit, following which telehealth-delivered services may occur.
- The length, format, and treatment goals of telehealth sessions will be identical to those of face-to-face visits.
- Telehealth-delivered services will be documented in the electronic medical record in accordance with the standards that regulate face-to-face visits.

Patients who cannot be managed safely in an outpatient setting will be evaluated for hospitalization, per standard care protocol.

How Does That Make You Feel?
For more information about University emotional and mental health resources, visit www.rochester.edu/well-u/emotional.

For more information about BHP
visit www.bhp.urmc.edu or call (585) 276-6900.

Use your health care dollars effectively and make informed decisions about what kind of care you need.

Access Online Services

Excellus BlueCross BlueShield (www.excellusbcbs.com/ur)
Excellus BlueCross BlueShield provides an array of online services, programs, and member discounts. Here are a few of the available benefits.

- Research over 6,000 health topics using Healthwise Knowledgebase.
- Learn to live a healthier lifestyle with Health Improvement Programs to help you change your habits.
- Use the Personal Health Record to store your health information online for easy access.
- Use the Healthcare Advisor to estimate treatment costs, evaluate treatment options, and more.
- Have fun and learn something new with weekly Health Quizzes.
- Locate doctors and other health care professionals in your area who participate in your plan through "Find a Doctor."
- Print temporary ID cards.

Excellus BlueCross BlueShield Pharmacy (www.excellusbcbs.com/ur)

- Use the Pharmacy Locator to identify participating pharmacies in your local area.
- Use the Mail Order Pharmacy, Wegmans Home Delivery or Express Scripts Home Delivery, and pay less for a 90-day prescription.
- View and print your claims history.
- View a list of specialty medications.
- Search for and compare prices on lower cost drug options.
- Ask a licensed, clinical pharmacist your questions.

Use Member Discounts

Excellus BlueCross BlueShield offers discounts on health and wellness, family care, financial well-being, and travel services through Blue365.

Use Your Personal Health Record to Make Smart Health Care Decisions

When enrolled in a University Health Care Plan through Excellus BlueCross BlueShield, you and your covered dependents each have access to your own online Personal Health Record. This confidential resource will store any claims information you enter and provide you with convenient access to a range of health data. You can store your family's health information online for easy access. And, you can print a report to take to your next doctor's appointment or when you travel.

Don't Have a Personal Physician? You Should. Here's Why.

Better health. Establishing a relationship with a primary care physician (PCP) is very important when it comes to staying healthy. Visiting the same physician for preventive and regular health care is one way that you and your family can be smart health care consumers and potentially save money. Getting the right health screenings each year can reduce your risk for many serious conditions. Not only will your PCP help you take advantage of preventive care covered at 100% by the University's Health Care Plans, a PCP is familiar with your health history and can help you determine what medical services are necessary. He/she is one of the few health care providers you'll see both when you're healthy and when you're ill.

Your PCP can also help coordinate any additional care you may need to seek from multiple specialists and is responsible for keeping a record of your medical history. Therefore, it's important to always let your PCP know if something has changed with regards to your health. For example, if you've been prescribed medication by two different specialists, your PCP will be able to help you understand if there is any risk to taking both medications.

Peace of mind. Advice from someone you trust is important when you're healthy, but it's even more important when you're sick. Your PCP is familiar with your health history as well as your family's health history: this in-depth knowledge allows your PCP to be better able to determine the signs and symptoms they need to be aware of, especially if you or your family members are at risk for certain conditions. Although visiting a PCP prior to scheduling an appointment with a specialist or receiving other medical services is not required by the University's Health Care Plans, it's recommended to keep your PCP informed of your health concerns so they can help you and your family efficiently and effectively manage your health.

A healthier wallet. Being able to call or visit your PCP when you are sick or need medical advice helps you avoid costly and possibly unnecessary trips to an Urgent Care facility or the emergency room (non-emergency visits to the emergency room are not covered by your Health Care Plan). If you do not have a PCP and are interested in establishing this relationship, please visit Excellus BlueCross BlueShield (www.excellusbcbs.com/ur) for information on in-network PCPs.

You also have access to Accountable Health Partner providers, a panel of University of Rochester Medical Faculty Group providers and carefully selected

community partners created to improve the health of our employees and their dependents. When you visit an Accountable Health Partner provider, you'll receive a higher level of coverage on your out-of-pocket medical costs, plus you will have a lower deductible[4], copay[5], coinsurance[6], and out-of-pocket maximum[7].

To find Accountable Health Partners providers in your area, visit http://ahpnetwork.com/search-provider/.

Take Advantage of Prescription Drug Discounts

- You can receive discounts on your prescriptions and free delivery to most off-site University locations with daily courier service through the URMC Employee Pharmacy.
- You can also save money by asking your doctor if there are generic equivalents available for brand name drugs you may be prescribed.
- Use the mail order program for a 90-day supply prescription to get three times the supply for two and a half times the price.
- You may be eligible for discounts on prescriptions drugs used to treat a chronic condition or to save on diabetic supplies.
- Your copay for your first six months for a new generic drug will be waived when changing from a brand name to a generic drug.
- Employees on the PPO Plan have a feature added on their plan called SaveOn. The program offers savings for certain specialty prescription medications. [8]

4 The amount of out-of-pocket expenses that you must pay for health services before the Plan begins to pay benefits for many covered services

5 A fixed dollar amount you must pay to a provider at the time services are received

6 The percentage of the fee that the Plan pays for certain covered expenses once you have met your deductible

7 The maximum amount you pay each Plan Year to receive covered services after you meet your deductible. Once you meet your out-of-pocket maximum, the Plan pays 100% of covered services you receive. In-network and out-of-network services are subject to separate out-of-pocket maximums.

8 Employees are only eligible while enrolled in the PPO Plan due to rules and regulations surrounding High Deductible Health Care Plans (HSA-Eligible Plan).

Health Program

Health Care Plans, Vision Benefits, Prescription Drug Plan, Dental Plans, FSAs, and HSA

The Plans available through the University Health Program can help you be a better health care consumer. The key is to use these Plans to change your behavior—by becoming more involved in your health, taking more responsibility for making smart health care decisions, making healthy lifestyle choices, and using your benefits wisely.

The choices you make today—whether selecting health care coverage for you and your family for the upcoming year, or deciding when and how to use health care services on a day-to-day basis—have a direct impact on the health care costs you and the University pay tomorrow.

Your Health Care Plan Choices for 2022

The University of Rochester offers two Health Care Plans that focus on features that support the University's goals of fostering a culture of wellness, reducing health care expenses, and encouraging faculty and staff and SMH residents and fellows to take an active role in managing personal health. Take some time to understand the different Plan options available to you, so you select the Plan that is cost effective and appropriate for your needs—and those of your family.

Your Health Care Plan Options[9]

You can choose from the following options:

- YOUR HSA-Eligible Plan
- YOUR PPO Plan

You also may choose to waive health care coverage.

How the Health Care Plans Are Alike

Both plans:

- Are a PPO (Preferred Provider Organization)
- You can choose to receive care from:
  - Accountable Health Partners (Tier 1)
  - Providers within the Excellus national network (Tier 2)
  - Out-of-network[10] (Tier 3)
  - **Note:** You may pay more for services received within the Excellus national network (Tier 2) or out-of-network (Tier 3).
- Give you access to a nationwide network of doctors, hospitals, and treatment facilities that have agreed to charge lower, negotiated rates for care. You can choose to receive care in or outside of the TPA's network, but you may pay more for care outside of the TPA's network.
- Allow you to visit Accountable Health Partners providers, which provide a higher benefits level with a lower deductible, copay, coinsurance, and out-of-pocket maximum than using a TPA provider who isn't part of Accountable Health Partners.
- Do not require that you have a PCP, but it is recommended that you select one, and referrals are not required for specialists or other necessary health care services.
- Emphasize preventive care with 100% in-network coverage to encourage regular check-ups and wellness services. **Note:** All care is subject to meeting the clinical policies established by Excellus.
- Require you to pay more if you choose a brand name drug when a generic equivalent exists. You will be responsible for the copay plus the cost difference between the brand name and generic equivalent, even if your doctor prescribes a brand name drug unless the generic is medically inappropriate in accordance with Excellus's medical management guidelines such as if it is ineffective, not available at retail locations, or has dangerous side effects.

9 Health care plan options for Postdocs are not described in this booklet, but rather in the separate certificate of coverage.

10 Doctors, hospitals, or other health care facilities that are not affiliated with the third-party administrator you have selected. When you use a doctor, hospital, or other health care facility that does not participate in the network, your out-of-pocket costs are higher because these providers have not agreed to accept discounted rates and because the benefit coverage is generally lower.

- Will decrease your copays/coinsurance or the out-of-pocket cost for prescription drugs that are filled at the University of Rochester Employee Pharmacy.
- Provide similar discounts for a 90-day supply of prescription drugs through the University of Rochester Employee Pharmacy and mail order program.
- Require you to purchase specialty drugs from the University of Rochester Employee Pharmacy.

How the Health Care Plans Differ

The Health Care Plan options vary when it comes to what you pay for:

- Your employee contributions for the Plan option you choose, and
- Your deductibles, coinsurance, copays, and out-of-pocket maximums when you receive care.

Additionally, the options offer different pre-tax accounts—the YOUR HSA-Eligible Plan includes the option to contribute to an HSA and a Limited Purpose Health Care FSA, while the YOUR PPO Plan allows you to contribute to a Health Care FSA.

If you enroll in the YOUR HSA-Eligible Plan but do not elect to have an HSA, you can elect to contribute to a Health Care FSA. You can only contribute to a Limited Purpose Health Care FSA if you elect to contribute to an HSA.

Deductibles/Out-of-Pocket Maximums

The YOUR PPO Plan (for inpatient, outpatient, urgent care, emergency room visits, and out-of-network care) includes embedded single deductibles within the family deductibles and out-of-pocket maximums for each of the three plan tiers. If you are enrolled in the Plan for Employee and Child(ren), Employee and Spouse/Domestic Partner, or Family coverage, once one family member satisfies the single deductible, the Plan will begin to reimburse eligible health care expenses for that family member. If you are enrolled in two-person coverage (i.e., employee and spouse or employee and child), each member would satisfy the single deductible; the family deductible would not apply. The same rule applies to the out-of-pocket maximum; all copays, including pharmacy copays, will also be covered at 100% once the out-of-pocket maximum is met. Any combination of eligible expenses for covered family members can be used to meet the family annual deductible/out-of-pocket maximum, at which point all family members will have met the deductible/out-of-pocket maximum requirements; the deductibles and out-of-pocket maximums cross-apply between AHP, in-network, and out-of-network providers.

The YOUR HSA-Eligible Plan requires that the family deductible be met (for any coverage level other than Single), before coinsurance will begin for any family member.

Similarly, the YOUR HSA-Eligible Plan requires that the family out-of-pocket maximum be met (for any coverage level other than single), for Tier 1/Accountable Health Partners and Tier 3/Out-of-Network before the Plan will cover expenses at 100% for any family member. The YOUR HSA-Eligible Plan includes an embedded out-of-pocket maximum (OOPM) for Tier 2 services. There is a $7,550 embedded individual OOPM included in the family OOPM. If any individual in your family incurs $7,550 of eligible claims expenses during the plan year, the plan will pay 100% of that individual's covered expenses for the remainder of the year, even if the family has not reached the family out-of-pocket maximum.

Example of Embedded Family Deductible

If you are a family of four (yourself, your spouse/domestic partner, and two children), visit Accountable Health Partners providers, and you are enrolled in the YOUR PPO Plan, the deductible would work as follows:

- If you receive in-network care and satisfy the single deductible of $500, the Plan will begin to pay coinsurance for you.
- If your spouse receives health care services and satisfies his or her single deductible of $500, the Plan will begin to pay coinsurance for him or her*. So far, you have applied $1,000 to the $1,250 family deductible, because the single deductibles count towards the family deductible.
- This means that when the next person in your family receives health care services, he or she only has to pay $250 before the Plan begins to pay coinsurance, because your family will have met the $1,250 deductible.
- Once the $1,250 family deductible is satisfied, all members will be subject to coinsurance with no further deductible requirements, assuming care is received in-network.

The out-of-pocket maximums follow the same pattern as the deductibles but include all copays, including pharmacy expenses in addition to eligible medical expenses.

* If you have one dependent on your plan (i.e., employee and spouse), you would each satisfy the single $500 deductible; the $1,250 family deductible would not apply.

University Health Care Plans—An Overview

In 2022, you can choose between the YOUR HSA-Eligible Plan and the YOUR PPO Plan. Both Plans cover the same services and are designed to help you take control of your health and the dollars you spend on your health care.

Only you can decide which Plan is best for you. You owe it to yourself and your dependents to assess how you think you will use benefits in the coming year (e.g., annual physicals, medications) and determine which benefit options will help you maximize your savings while meeting your health care needs.

Key Features of Each Plan

	YOUR PPO Plan	YOUR HSA-Eligible Plan
Need to meet a deductible?	Yes, except for preventive care services, which are covered at 100%, or for PCP or specialist office visits, which are subject to copay or coinsurance, but not subject to a deductible.	Yes, except for preventive care services, which are covered at 100%.
Covers prescription drugs?	Yes, you pay your share of the copay (generic) or coinsurance (preferred brand and non-preferred brand) until you reach the out-of-pocket maximum.	Yes, after the deductible, you pay your share of the copay (generic) or coinsurance (preferred brand and non-preferred brand) until you reach the out-of-pocket maximum.
100% coverage after meeting the out-of-pocket maximum?	Yes	Yes
Use the plan with an HSA?	No, but you will have access to a Health Care FSA.	Yes

The chart below provides a high-level overview of the main features of each Plan. For a more detailed look at both plans, refer to the Health Plans Comparison Chart on the Office of Total Rewards website.

	YOUR PPO Plan			YOUR HSA-Eligible Plan		
	Excellus Using AHP Network	Excellus National Networks	Out-of-Network	Excellus Using AHP Network	Excellus National Networks	Out-of-Network
Deductible (Rx included)*						
Single	$500	$1,250	$3,000	$1,500	$2,250	$4,000
Family	$1,250	$3,125	$9,000	$3,000	$4,500	$8,000
Out-of-Pocket Maximum (Rx and deductible included)‡						
Single	$2,750 ($2,000§)	$4,250 ($3,000§)	$6,500 ($5,000§)	$3,000 ($2,500§)	$4,500 ($4,000§)	$6,750
Family†	$5,500 ($4,000§)	$8,500 ($5,500§)	$13,000 ($10,000§)	$6,000 ($5,000§)	$9,000 ($8,000§)	$13,500
Service Coverage						
Preventive Care	100%, no deductible		Not covered	100%, no deductible		Not covered
Office Visit	$20 copay	$35 copay	60%, after deductible	90%, after deductible	75%, after deductible	60%, after deductible
Specialist Visit	$35 copay	$65 copay				
Urgent Care	90%, after deductible	75%, after deductible				
Emergency Room	90%, after Tier 1 deductible			90%, after Tier 1 deductible		
Inpatient	90%, after deductible	75%, after deductible	60%, after deductible	90%, after deductible	75%, after deductible	60%, after deductible
Outpatient						

	YOUR PPO Plan		YOUR HSA-Eligible Plan	
Prescription Drugs¶				
Retail (up to 30-day supply)	• Retail, Generic (up to 30-days' supply): $15 copay • Retail, Preferred Brand (up to 30-days' supply): You pay 20% coinsurance ($25 min, $60 max) • Retail, Non-Preferred Brand (up to 30-days' supply): You pay 35% coinsurance ($50 min, $120 max)	Not covered	• Retail, Generic (up to 30-days' supply): $15 copay, after deductible • Retail, Preferred Brand (up to 30-days' supply): You pay 20% coinsurance ($25 min, $60 max), after deductible • Retail, Non-Preferred Brand (up to 30-days' supply): You pay 35% coinsurance ($50 min, $120 max), after deductible	Not covered
Mail Order (up to 90-day supply)#	2.5 times 30-day retail		2.5 times 30-day retail, after deductible	
Prescription Diabetic Supplies and Equipment	You pay 10% coinsurance (no deductible; $15 maximum)		You pay 10% coinsurance after deductible	
FSA/HSA Maximum Annual Contributions				
HSA	N/A		$3,650 Single / $7,300 Family	
Health Care FSA	$2,750		$2,750 (Only available if you do not contribute to an HSA)	
Limited Purpose FSA	N/A		$2,750 (Only available if using an HSA)	

* *Your Tier 3 deductible may only be met through receiving services from Tier 3 providers. The cost of services received from Tier 1 and Tier 2 providers will continue to accrue together.*

† *For the YOUR HSA-Eligible Plan, it is required that the family deductible be met for any coverage level other than Single, before Plan payments will begin, and similarly, the out-of-pocket maximum must be met for Tiers 1 and 3 before the Plan covers expenses at 100%. Tier 2 includes an embedded individual $7,550 out-of-pocket maximum for individuals with any coverage level except single. For the YOUR PPO Plan, individual deductibles and out-of-pocket maximums apply to any individual's claims for family coverage. However, when the sum of any combination of individual deductibles or out-of-pocket maximums reaches the family level, the family deductible or out-of-pocket maximum will be met for all family members.*

§ *Full time earning less than $64,000.*

¶ *If you are prescribed a brand name drug when a generic equivalent exists, you will generally be responsible for the copay plus the cost difference between the brand name and generic equivalent. All prescription drugs, including Specialty Drugs, filled at the URMC Employee Pharmacy qualify for a discount under the YOUR PPO Plan and the YOUR HSA-Eligible Plan. Under the YOUR PPO Plan, Oral Chemotherapy drugs will be covered at 100%; under the YOUR HSA-Eligible Plan, they will be subject to the deductible and coinsurance. Specialty Drugs must be filled at the UR Employee Pharmacy. SaveOn Program under the YOUR PPO Plan offers savings for certain specialty prescriptions. Some preventive drugs are considered preventive care and are covered at 100%.*

\# *90-day supplies of maintenance drugs filled at the URMC Employee Pharmacy are eligible for a reduction in copays.*
Note: Expenses for out-of-network services that count toward the out-of-pocket maximum include your out-of-network deductible and the maximum reasonable and customary coinsurance amounts considered under your Plan as developed by Excellus for covered expenses. Expenses above the determined reasonable and customary costs do not count toward the out-of-pocket maximum.

Excellus as Your TPA

If you enroll for coverage under the University Health Care Plans, Excellus BlueCross BlueShield will be your health care plan administrator. Review the information below to learn more about the services available to you.

	Excellus BlueCross BlueShield
Provider Networks	Excellus maintains its own national network of providers and reimburses them at different levels. You may want to confirm that the providers you and your family use are participating providers.
To locate a network provider	To locate an Excellus BlueCross BlueShield provider, refer to "Find a Doctor" at www.excellusbcbs.com/ur. Please refer to the links when you scroll down the page and select the appropriate link to find a local, national, or international provider.
Preventive Services Coverage	Preventive services are covered at 100% if you use an in-network provider (including an Accountable Health Partners provider). To ensure 100% coverage, you should confirm that the service you are seeking is preventive, as determined by Excellus, and that your doctor will bill Excellus appropriately. All care is subject to meeting the clinical policies established by Excellus who administers your University Health Care Plan. Excellus may apply different medical management techniques and frequency guidelines for preventive care.
Preventive Care Guidelines	www.excellusbcbs.com/ur
Prescription Drugs	Excellus will provide your prescription drug coverage.
Drug formularies/ copays	The Excellus BlueCross BlueShield three-Tier drug formulary will be used to determine the level of copay(s) or coinsurance you will be responsible for, depending on the medication prescribed. Please refer to the Excellus website listed below designated for the University of Rochester's Pharmacy Benefits program to identify the copay(s) and coinsurance that applies to your and/or your dependents' medications as well as other Pharmacy Benefits Program information. www.excellusbcbs.com/ur
Mail order	Wegmans Home Delivery, 1-800-586-6910 Express Scripts Home Delivery, 1-855-325-5220 https://www.excellusbcbs.com/wps/portal/xl/prescription-drugs/mail-service-pharmacy/
Health Savings Account (HSA)	HSA Bank will administer your HSA. The University will pay the monthly administration fee as long as you remain enrolled in the YOUR HSA-Eligible Plan.
Investing*	Your funds are held by HSA Bank in an interest-bearing account. Current account interest rates are available online at the website listed below. There is no minimum balance required, and the monthly administrative fee is paid by the University while you are enrolled in the YOUR HSA-Eligible Plan. Alternate investment options are available through a self-directed investment option with TD Ameritrade. No minimum account balance is required. Trading fees may apply and are available in the investment prospectus. In addition to TD Ameritrade, HSA Bank offers Devenir Investment Advisors as an option. There is an annual fee charged by the Mutual Fund Selection vendor; however, no trading fees apply. www.hsabank.com
* *The University does not endorse any particular HSA provider. This section describes the HSA provider with which the University has established an administrative relationship for contributions through University payroll. This does not constitute investment advice. You may find another HSA trustee/custodian with better investment returns on your own.*	
Automatic payment/debit	You will automatically receive a debit/credit card that you can use to pay for out-of-pocket expenses. If you use as a debit card, additional fees may apply.
	You can also have the following options at no cost: • Mobile app—Ability to pay a claim directly from your HSA account using the Mobile App • Online Bill Payment—An easy way to pay for expenses directly from your HSA to your doctors, hospitals, dentists, and more • Online Transfer—Transfer money to a personal checking or savings account to reimburse yourself for a paid expense.
	Over-the-Counter Medications As a result of the CARES Act, qualified expenses now include: over-the-counter medicine without needing a doctor's prescription and all feminine hygiene products.
	Important: Regulation for Domestic Partners and FSA/HSA Reimbursements Your domestic partner must be considered your federal tax dependent in order for their health care expenses to be eligible for reimbursement from your HSA. If you use HSA funds to pay for expenses for a domestic partner who is not a qualified tax dependent, those funds are taxable, subject to a tax penalty, and must be reported on your federal tax return.

	Excellus BlueCross BlueShield
Withdrawing funds manually	You can transfer funds to a personal account, pay bills online, or withdraw your funds by check, for a fee, by written withdrawal forms. There is a checkbook fee for 50 checks and 10 deposit tickets. Fee comes out of your HSA.
Account access	You can manage your HSA activity online anytime, day or night. Log on to http://hsabank.com to view your HSA balance, account summary, and account activity.
Flexible Spending Accounts (FSAs)	Lifetime Benefits Solutions, Inc. is the FSA Administrator for Excellus BlueCross BlueShield.
Automatic payment/debit	**Health, Pharmacy, and Dental:** Out-of-pocket health care, pharmacy, and dental expenses will be automatically reimbursed from your FSA through ACT, including mail order through Wegmans Home Delivery or Express Scripts Home Delivery, after the claim has been processed if a University Plan is your primary plan. If you enroll in Medicare, you will need to manually submit claims. **Note:** The Limited Purpose Health Care FSA does not include automatic payments and debits. You will need to file your expenses manually. You may opt out of ACT. Claims not paid through ACT will need to be filed manually. If you cover your domestic partner, or their children on your University Health Care Plan and they are not your tax dependents, you must turn off the automatic reimbursement feature. **Note:** If you, your spouse/domestic partner (tax dependent), or dependent child has secondary health plan coverage (Medicare, spouse's employer plan, Medicaid, or other plan coverage) requiring coordination of benefits, you are required to contact Excellus/Lifetime Benefit Solutions and turn off the auto reimbursement feature, and you will need to file claims manually. If you cover your domestic partner or their children on your University Health Care Plan and they are not your tax dependents, you are required to turn off the automatic reimbursement feature. The Limited Purpose Health Care FSA does not include the automatic reimbursement feature, and you will need to file your expenses manually. You may opt out of automatic reimbursement from your FSA. Claims not paid through automatic reimbursement will need to be filed manually. The Plan may seek to recover reimbursed unqualified funds. Reimbursement of unqualified medical may be subject to taxes and tax penalties.
	Prescription Drugs: You must pay the respective copay(s)/coinsurance at the point of sale, and you will be automatically reimbursed by Excellus BlueCross BlueShield through ACT.
	Over-the-Counter Medications: As a result of the CARES Act, qualified expenses now include: over-the-counter medicine without needing a doctor's prescription and all feminine hygiene products. The auto-debit feature may not process for these purchases, and you may need to file a manual claim for reimbursement.
	Dependent Care: You will need to file your out-of-pocket expenses manually.
	Important: Regulation for Domestic Partners and FSA/HSA Reimbursements Your domestic partner must be considered your federal tax dependent in order for their health care expenses to be eligible for reimbursement from your HSA, Health Care FSA, or Limited Purpose FSA. If you use HSA, Health Care FSA, or Limited Purpose FSA funds to pay for expenses for a domestic partner who is not a qualified tax dependent, those funds are taxable, subject to a tax penalty and must be reported on your federal tax return. The Plan may seek to recover such funds. If your domestic partner is **not** your federal tax dependent, and you are normally reimbursed through ACT, you are required to turn off this reimbursement feature. The same rules apply for the children of your domestic partner.
Submitting claims manually	Reimbursement forms are available from the Office of Total Rewards or can be printed from rochester.edu/totalrewards/fsa. Claims can also be submitted online at www.lifetimebenefitsolutions.com. After submitting claims online, all receipts and supporting documentation must be faxed to Lifetime Benefits Solutions, Inc. at 1-877-256-7228. You can also submit a claim and upload receipts right from your phone with the app and your phone's camera or directly online through the LBS website noted above. Claims are paid on a weekly basis and can be reimbursed to you by check or direct deposit.
Minimum reimbursement	There is a $30 check minimum. If you have direct deposit, there is no reimbursement minimum.
Account access	To submit claims, check FSA balances, and view payment information, including pending claims and reimbursements paid, log on to www.lifetimebenefitsolutions.com. Or call customer service at (585) 232-2632 or 1-800-327-7130.

Additional information regarding coverage available under Excellus BlueCross BlueShield can be found in the benefit booklet, which is available from the Office of Total Rewards and considered part of the SPD.

Health Plan Resources Available to You

A variety of resources are available to help guide your decision about which health Plan may provide the best coverage and value for your money.

Provider Search Tools

Go to www.excellusbcbs.com and select Find A Doctor, then Find A Doctor/ Provider to find a local provider. To find an AHP provider, visit the AHP website at www.ahpnetwork.com or call 1-888-457-7463.

Remember!
Visiting an Accountable Health Partners provider gives you an even greater level of savings on cost sharing. To find Accountable Health Partners providers in your area, visit http://ahpnetwork.com/search-provider/ or call 1-888-457-7463.

Cost of Care Estimating Tools

Excellus BlueCross BlueShield offers personalized cost estimator tools to facilitate Plan selection and other resources to help take the challenge out of benefits selection, make informed health care decisions, and know what you may pay out of pocket before ever making an appointment.

To access the Treatment Cost Advisor and Provider Selection Advisor tools:

- Go to www.excellusbcbs.com/ur and click on Log in/Register near the top of the page.
- Type in your login and password (first-time users will have to register and create an account).
- Click on Resources, and then Estimate Treatment Costs.

Out of Area Payment Program
Active employees enrolled in a University Health Care Plan who must reside and perform their University work in a county outside of AHP's provider network geographic locations—due to the business needs or nature of a particular position for the University—may be eligible to receive a semiannual compensation adjustment. Individuals must be actively working in the eligible position at the time of reimbursement. Currently, the AHP provider network locations include the following thirteen counties: Allegany, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Schuyler, Steuben, Wayne, Wyoming, and Yates. If you believe you are eligible for this program, please have your supervisor or manager contact the Office of Total Rewards.

Flexible Spending Accounts and Health Savings Account

The University offers two ways to help you save on taxes when you have eligible health care, dental, and/or dependent care expenses. They are:

- Flexible Spending Accounts (FSAs)
  - Health Care FSA (for those eligible for a University Health Care Plan)
  - Limited Purpose FSA (for those enrolled in the YOUR HSA-Eligible Plan and contributing to an HSA)
  - Dependent Care FSA (for dependent day care expenses)
- Health Savings Account (HSA) (for those enrolled in the YOUR HSA-Eligible Plan)

A Flexible Spending Account (FSA)

FSAs offer you a great way to save on eligible health care or dependent care expenses. If you participate, you choose how much to contribute for the Plan Year. Each pay period, your contributions are automatically deducted from your paycheck in equal amounts—before taxes—and deposited into your FSA. Then, when you incur an eligible expense, you get reimbursed from your account. Since you are using tax-free money to pay for your eligible expenses, you reduce your taxable income, save on taxes, and increase your take-home pay.

Carrying Over FSA Funds

According to IRS rules, your elected FSA contributions can only be used to reimburse expenses incurred between January 1, 2022, and December 31, 2022. You may be eligible to roll over a certain amount of unused Health Care FSA or Limited Purpose FSA funds to the following plan year if you make an active election during Open Enrollment to contribute to your FSA in the upcoming plan year. See the Total Rewards website for the most up-to-date details. If no election is made, unused funds will be forfeited. You will have until April 30, 2023, to file your 2022 claims.

A Health Savings Account (HSA)

An HSA can help you manage your health care and save for future health care expenses. In fact, it can offset the cost of the deductible and other out-of-pocket costs of the YOUR HSA-Eligible Plan.

It also offers the potential for some significant tax advantages. Contributions you make to your HSA are tax deductible and earn interest tax-free. HSA funds also are not taxed when withdrawn to pay for qualified health care expenses.

An HSA is like having your own health care checking or savings account. How you use the funds in your HSA is entirely up to you—you can use them to pay for eligible health care expenses until you meet your deductible, or you can save them for future expenses. You will not pay federal income taxes on your HSA as long as you use the funds for qualified health care expenses.

HSA Regulations

- You cannot be reimbursed for any health care expenses incurred before your HSA is established.
- You cannot contribute to an HSA if you are eligible to be claimed as someone's dependent on their tax return.
- You cannot be enrolled in another health care plan—for example, through your spouse or Medicare (Parts A, B, C, and/or D).
- You or your spouse cannot enroll in a Health Care FSA through the University or another employer; however, you or your spouse may enroll in a Limited Purpose Health Care FSA through the University or another employer.
- You cannot contribute to an HSA if you or your spouse has an HRA that could reimburse your claims.
- Expenses for domestic partners and their children are not eligible for reimbursement from the HSA on a pre-tax basis unless they are your tax dependents under the Internal Revenue Code.
- Only certain types of expenses are eligible to be paid by funds in an HSA. Distributions from your HSA will be reported to you and the IRS on Form 1099-SA for all withdrawals even if they were used to pay for qualified expenses and are not taxable. If the distribution was used for a non-qualified expense, such as an over-the-counter medication, you must report that amount as income on your federal tax return and you also may be required to pay a 20% excise tax. Please consult with your tax advisor for more information.

HSA or Health Care FSA—What Is Right for You?

The University of Rochester gives you the opportunity to contribute pre-tax dollars that you can use to pay for eligible health care, dental, and vision expenses not paid for by either plan. The HSA is available when you enroll in the YOUR HSA-Eligible Plan and meet the eligibility requirements set by the IRS. The Health Care FSA is available if you select the YOUR PPO Plan or YOUR HSA-Eligible Plan (if you are not contributing to an HSA), or waive coverage. (With the YOUR HSA-Eligible Plan, if you are contributing to an HSA, you may also contribute to a Limited Purpose Health Care FSA.) The types of expenses the accounts cover are similar but not identical. Because you do not pay FICA or federal income taxes on money you contribute to these accounts, they are worth considering no matter how small your out-of-pocket expenses may be in a year. Which option—if any—is right for you? Here is a quick comparison to help you think about your decision.

	HSA	Health Care FSA	Limited Purpose Health Care FSA
Plans Associated with These Accounts	YOUR HSA-Eligible Plan	YOUR PPO Plan (Note: You may also enroll in the Health Care FSA if you choose not to enroll in medical coverage through the University, or if you enroll in the YOUR HSA-Eligible Plan but do not contribute to the HSA)	YOUR HSA-Eligible Plan, if already contributing to an HSA
Funding Maximums	You fund with before-tax dollars, up to a maximum of $3,650 individual/$7,300 family*. In 2022, the University will provide a one-time HSA contribution of $200 individual/$400 family for full-time employees earning less than $64,000 and Residents and Fellows who enroll in the YOUR HSA-Eligible Plan during the Open Enrollment and satisfy the IRS eligibility requirements. We will also provide a prorated contribution to full-time employees earning less than $64,000 and Residents and Fellows if they are new hires, rehires, or newly eligible employees as well as employees or Residents and Fellows experiencing a qualifying event.	You fund with before-tax dollars, up to a maximum of $2,750 per Plan Year.	You fund with before-tax dollars, up to a maximum of $2,750 per Plan Year.
Making Changes	You can enroll in, increase, or decrease your contributions at any time during the year but no more than once a month.	You may make a change during the year only if you have a qualified status change.	You may make a change during the year only if you have a qualified status change.
Availability of Funds for Use	Your contributions accrue throughout the year. You only have access to funds currently in your account.	Entire fund amount elected for the plan year is available for use as of January 1, regardless of when the actual funds are deposited in the account.	Entire fund amount elected for the plan year is available for use as of January 1, regardless of when the actual funds are deposited in the account.
Covered Expenses	Eligible health care expenses or noneligible expenses with a 20% penalty and FICA, while the HSA is open.	Eligible health care expenses incurred throughout the year.	Eligible dental and vision expenses incurred throughout the year and post-deductible medical expenses.
Portability	You can take your HSA with you if you leave the University, change your plan, or retire. You can also elect a beneficiary.	You cannot take your FSA with you if you leave the University; you may elect COBRA.	You cannot take your FSA with you if you leave the University; you may elect COBRA.

	HSA	Health Care FSA	Limited Purpose Health Care FSA
Rollover	Any unused funds in the account at the end of the year will roll over to the next year.	You may be able to roll over certain unused Health Care or Limited Purpose FSA funds to the following year. Please see the Total Rewards website for additional details.	You may be able to roll over certain unused Health Care or Limited Purpose FSA funds to the following year. Please see the Total Rewards website for additional details.

* *If you are age 55 or older, you may contribute an extra $1,000 through pretax payroll deductions to your account for 2022.*

Remember, your domestic partner must be considered your federal tax dependent in order to use HSA, Health Care FSA, or Limited Purpose FSA funds to be reimbursed for his or her health care expenses. If your domestic partner is covered on your health and/or dental plan and is not your federal tax dependent, their medical and dental expenses cannot be reimbursed by your FSA. You must contact your FSA administrator to request they cancel the automatic reimbursement feature to avoid FSA reimbursements for your domestic partner's expenses.

Tax Savings Beyond Health Care: Dependent Care FSA

Dependent Care FSA

The Dependent Care FSA is designed to help you reduce your taxes while you pay for dependent care expenses, which permit you and your spouse to work outside the home or to attend school on a full-time basis.

The Dependent Care FSA generally covers day care expenses for:

- Children under age 13 and
- A mentally or physically impaired spouse/domestic partner or a dependent who is incapable of caring for himself or herself (for example, an invalid parent) who lives with you at least eight hours a day.

Only employees who have eligible dependents are permitted to participate. If the plan learns that you have no eligible dependents, you will be automatically removed from participation in the Dependent Care FSA.

You decide in advance how much to set aside for the coming Plan Year. During the year, if eligible expenses arise, you are reimbursed with monies from your account. You can only be reimbursed up to the amount in your FSA when the reimbursement request is made. Employees with funds in a Dependent Care FSA as of December 31 can submit reimbursement requests through April 30 of the following year for qualified expenses incurred in the previous calendar year. Please refer to the chart at the bottom of the page to determine how much you can contribute annually.

Child care services will qualify for reimbursement from the Dependent Care FSA if they meet these requirements:

What You Can Contribute to a Dependent Care FSA	
Based on your tax status . . .	**You can set aside . . .**
If you are single, married filing jointly, or head of household	A minimum of $100, up to $5,000
If you are married filing jointly and your spouse's employer offers a Dependent Care FSA	A minimum of $100, up to $5,000 in total between the two accounts
If you are married filing separate returns	A minimum of $100, up to $2,500

Federal non-discrimination guidelines require the University to test the Dependent Care FSA to ensure that highly compensated employees, as defined under IRS guidelines, do not disproportionately contribute to the Dependent Care FSA. Highly compensated employees may have their FSA maximum contribution amount reduced if the test results do not meet federal guidelines.

Expenses That Are Not Reimbursable through a Dependent Care FSA

- Health care expenses for your dependents
- Expenses incurred before the effective date of your FSA
- Expenses for those who are not your eligible dependents
- Dependent care expenses that are provided to one of your dependents by a family member, unless the family member is age 19 or older by the end of the year and will not be claimed as a dependent
- Expenses for food and clothing
- Educational expenses, other than pre-school (if the cost of kindergarten schooling can be separated from the cost of child care, reimbursement is appropriate only for the child care portion)
- Overnight camps

- The services may be provided inside or outside your home but not by someone who is your minor child, your spouse, or the child's parent (if the child is under 13), or dependent for income tax purposes (for example, an older child).
- If the services are provided by a day care facility that cares for six or more children at the same time, it must comply with all applicable state and local laws and regulations.
- The services must be incurred to enable you, or you and your spouse if you are married, to be gainfully employed.
- The amount to be reimbursed must not be greater than your income or the combined income of an employee and spouse, whichever is lower.
- Services must be for the physical care of the child, not for education, meals, etc.

Allowable dependent care expenses include payments to the following when the expenses enable you, or you and your spouse if you are married, to be gainfully employed:

- Child care centers
- Family day care providers
- Babysitters
- Nursery schools
- Caregivers for a disabled dependent or spouse who lives with you
- Household services, provided that a portion of these expenses are for a qualifying dependent incurred to ensure the dependent's well-being and maintenance
- Before and after school care
- Day camps

In the case of divorced or separated parents, a child is treated as a dependent of the custodial parent (the parent having custody for the greater portion of the calendar year) only.

Choose Your Dental Benefits

Maintaining good health starts with good habits, like seeing your dentist regularly. The University of Rochester helps you maintain your dental health by providing you with the choice of two Dental Plans. The Dental Plans are administered by Excellus BlueCross BlueShield.[11]

Eligible employees have the choice of the:

- Traditional Dental Assistance Plan
- Medallion Dental Plan

Regardless of which Dental Plan you select, you may visit the dentist of your choice. You may save more on your dental expenses if you visit a dentist who participates with Excellus BlueCross BlueShield.

More than 600 area dentists currently participate with Excellus BlueCross BlueShield. To view a list of participating dentists, go to www.excellusbcbs.com/ur and click Find a Doctor toward the top, then select Find a Dentist from the drop-down menu or call Excellus's Customer Service at 1-800-659-2808 to request a print copy free of charge.

11 Excellus BlueCross BlueShield reserves the right to pay for a less expensive treatment, if appropriate.

Dental Plan Highlights
Note: Excellus BlueCross BlueShield reserves the right to pay for a less expensive treatment, if appropriate.

	Traditional Dental Assistance Plan	Medallion Dental Plan
Details	The Dental Plans allow you the freedom to see any dentist you choose. However, non-participating dentists are not obligated to accept Excellus BlueCross BlueShield's allowed amounts as payment in full and will balance bill any amount in excess of Excellus BlueCross BlueShield's allowed amounts. It is recommended that you request a Predetermination of Benefits prior to receiving any care expected to exceed $300 by a non-participating dentist.	
Enrollment	Coverage for eligible faculty and staff members is effective the first of the month following your date of appointment or on the date of appointment if it occurs on the first of the month. Coverage for Residents and Fellows is effective the date of hire or appointment. Your enrollment form must be received by the Office of Total Rewards within 30 days of when you become benefit-eligible.	
Cost of coverage (retirees pay premiums based on Post-Retirement Grandparent Level)	You pay a share of the premium through pre-tax payroll deductions.	

Dental Plan Highlights *Note: Excellus BlueCross BlueShield reserves the right to pay for a less expensive treatment, if appropriate.*		
Maximum benefit per calendar year (per participant)	$1,000	$2,000 (For orthodontia, each eligible dependent under age 19 has a separate individual lifetime maximum of $1,500. No more than one-half of the lifetime maximum will be paid in any calendar year.)
Benefit Deductible*	$50 Single/$150 Family	
Preventive Services (Class I) (includes cleaning and exams, sealants, bitewing X-rays, space maintainers, fluoride treatments covered up to age 16, emergency palliative treatment, and dental prophylaxis)	Plan pays 100% of in-network negotiated rates, no deductible (Out-of-network claims are subject to balance billing.)	
Basic Restorative Services (Class II and IIA)		
Class II (includes fillings and simple extraction oral surgery)	Plan pays 80% after deductible (Out-of-network claims are subject to balance billing.)	
Class IIA (includes oral surgery, endodontics, periodontal surgery, periodontal scaling and root planning, and periodontal maintenance following surgery)	Plan pays 80% after deductible (Out-of-network claims are subject to balance billing.)	
Major Restorative Services (Class III) (includes fixed prosthetics, removable prosthetics, inlays/onlays/crowns, refines/rebases, implants)	Plan pays 15% after deductible	Plan pays 50% after deductible
Orthodontia (Class IV) (include orthodontia—only available for eligible dependents under age 19)	Not covered	Plan pays 50%, no deductible, up to lifetime maximum (see "Maximum benefit per calendar year" above). Orthodontia benefits are available only under the Medallion Dental Plan for eligible dependents under age 19. Enrollment in the Medallion Plan must be maintained during the entire course of the orthodontia treatment.
Predetermination of Benefits	Yes (Excellus BlueCross BlueShield reserves the right to pay for a less expensive treatment.)	

* *Individual deductibles are embedded within the family deductible.*

Choose Your Vision Benefits

The University offers eligible employees the option to enroll for voluntary vision benefits through the VSP Vision Plan. The University health care plans do not include vision coverage, therefore eligible employees have two options through VSP Vision Care: UR Vision Basic and UR Vision Plus.

Details of the VSP Vison Plan options are described in the certificate of coverage. A broad overview of those benefits follows:

UR Vision Basic Coverage with a VSP Provider		
Benefit	**Description**	**Copay**
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$35
Prescription Glasses		
Frame	• 20% off a complete pair of prescription glasses • A total $100 allowance for frame, lenses and lens enhancements, or contacts • Every calendar year	N/A
Lenses	• 20% off a complete pair of prescription glasses • A total $100 allowance for frame, lenses and lens enhancements, or contacts • Every calendar year	N/A
Lens Enhancements	• 20% off a complete pair of prescription glasses • A total $100 allowance for frame, lenses and lens enhancements, or contacts • Every calendar year	N/A
Contacts (instead of glasses)	• $100 allowance for contacts and contact lens exam; 15% savings on contact lens exam (fitting and evaluation) • Every calendar year	N/A
Extra Savings	**Glasses and Sunglasses** • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam	
	Laser Vision Correction • Average 15% savings on the regular price or 5% savings on the promotional price; discounts only available from contracted facilities	
Your Coverage with Out-of-Network Providers		
	Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services at 1-800-877-7195 for out-of-network plan details. • Exam up to $45 • Glasses up to $100 • Contacts up to $100	

UR Vision Plus Coverage with a VSP Provider		
Benefit	**Description**	**Copay**
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$20
Prescription Glasses		**$20**
Frame	• $220 featured frame brands allowance • $200 frame allowance • 20% savings on the amount over your allowance • $110 Walmart®/Sam's Club®/Costco® frame allowance • Every calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal,and lined trifocal lenses • Impact-resistant lenses fordependent children • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every calendar year	$0 $95–$105 $150–$175
Contacts (instead of glasses)	• $200 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60
PRIMARY EYECARE[SM]	• Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. • Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$0 $20 per exam
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam	
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
	Laser Vision Correction • Average 15% savings on the regular price or 5% savings on the promotional price; discounts only available from contracted facilities	
Your Coverage with Out-of-Network Providers		
	Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services at 1-800-877-7195 for out-of-network plan details. • Exam up to $45 • Frames up to $70 • Single Vision Lenses up to $30 • Lined Bifocal Lenses up to $50 • Lined Trifocal Lenses up to $65 • Progressive Lenses up to $50 • Contacts up to $185	

Non-Discrimination and Accessibility Notice

Strong Memorial Hospital and the University of Rochester Health Plans comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Strong Memorial Hospital and the University of Rochester Health Plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Strong Memorial Hospital and the University of Rochester Health Plans

- Provide free aids and services to people with disabilities to communicate effectively with us, such as
  - qualified sign language interpreters
  - written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as
  - qualified interpreters
  - information written in other languages

If you believe that Strong Memorial Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: SMH Grievance Coordinator, 601 Elmwood Ave Box 612, Rochester, NY 14642, phone: 585-275-0954, fax: 585-756-5584.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

For interpreter services, please email Interpreter_services@urmc.rochester.edu.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-585-275-4778（email: Interpreter_services@urmc.rochester.edu）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-585-275- 4778 (email: Interpreter_services@urmc.rochester.edu).번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

ةظوحلمةقرب لصتا .نانجملاب كل رفاوتت 1-585-275-4778 (رقم: اذإ ركذا تدجتت تنك ةغللا ،نإف تامدخ ةدعاسملا ةيوغللا (email: Interpreter_services@urmc.rochester.edu).:هاتف الصم والبكم

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں. 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-585-275-4778 (email:Interpreter_services@urmc.rochester.edu).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

Appendix A

When You Can Make Benefit Changes Outside of Open Enrollment

You can only enroll in or change your Health Care Plan options, Dental Plan, VSP Vision, and FSA contributions or add eligible dependents to your Health Care Plans, VSP Vision Care, or Dental Plan during the year if you experience a change that is a considered a qualifying event. **Changes due to a qualifying event must be received within 60 days of the qualifying event.**

Effective date of coverage will generally coincide with the qualifying event date. Where a coverage change is effective midway through a payroll period, your employee contribution for that payroll period will be determined based on your coverage election in effect as of the last day of the payroll period. For example, if an employee elected to add coverage midway through the payroll period, the employee would be charged the full (not prorated) employee contribution for that pay period, even if coverage was in effect for only part of the pay period. Likewise, if an employee elected to drop coverage midway through a payroll period, the employee would not be charged any payroll deduction for that pay period, even though coverage was in effect for part of the payroll period.

In most cases, newly benefit-eligible faculty and staff will have 30 days to enroll for benefits, and their Health Care and Dental Plan elections will be effective the first day of the month following or coinciding with the hire date. If you enroll by the 15th of the month, VSP Vision Care elections will be effective the 1st of the following month. If you enroll between the 16th and the 30th/31st, elections will be effective the 1st of the second following month. Newly benefit-eligible SMH residents and fellows will also have 30 days from their hire or appointment date to complete their benefit election, and their Health Care and Dental Plan enrollments will be effective as of their hire dates or appointment date. However, please note that benefit-eligible employees rehired within 30 days or less after termination, or who return tow work within 30 days or less after commencing a leave of absence (except in the case of FMLA or USERRA leave), shall automatically be reinstated in his or her pretermination (or preleave) elections unless another qualifying event permits a change. If an individual terminates employment with an affiliate of the University that does not participate in the Plan (for example, Highland Hospital), and is hired by the University within 30 days or less, then the employee will be able to enroll and make new elections in this Plan due to the change in worksite, but those election changes will be prospective only (i.e., coverage will not be retroactive to the date of hire).

Similar to midyear coverage changes, where enrollment for new hires is effective midway through a payroll period, your employee contribution for that payroll period will be determined based on your coverage election in effect as of the last day of the payroll period. For example, if your new hire coverage becomes effective midway through a payroll period, your employee share of the premiums for that payroll period will be the same as for an employee who had coverage for the entire payroll period.

HEALTH PLAN	DENTAL PLAN (Traditional & Medallion)	HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)*, §§	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)*, §§	EFFECTIVE DATE
You have the opportunity to change your benefits if you get married . . .				
You may enroll or add coverage for your spouse and any newly eligible dependents. You also may change coverage to another Plan option.† You may discontinue coverage for yourself and any dependents that gain coverage under your spouse's plan.§	You may enroll or add coverage for your spouse and any newly eligible dependents. You may also change coverage to another Plan option. You may discontinue coverage for yourself and any dependents that gain coverage under your spouse's plan.	You may enroll or increase election; may decrease election if become covered under spouse's plan.¶	You may enroll or increase election if the marriage increases dependent care expenses, may drop or decrease election if the marriage lowers expenses, or can be covered under spouse's plan.¶	Date of qualifying event.
You have the opportunity to change your benefits if your domestic partner becomes eligible for benefits#, ** . . .				
You may add coverage for your domestic partner and any newly eligible dependents to your current plan option on an after-tax basis if you are already enrolled for coverage. You may discontinue coverage for any dependents who were receiving coverage on an after-tax basis that gain coverage under your domestic partner's plan.§	You may add coverage for your domestic partner and any newly eligible dependents to your current Plan option on an after-tax basis if you are already enrolled for coverage. You may discontinue coverage for any dependents who were receiving coverage on an after-tax basis that gain coverage under your domestic partner's plan.	You cannot make any changes.	You cannot make any changes.	Date of qualifying event.
You have the opportunity to change your benefits if you get divorced or legally separated, or your marriage is annulled . . .				
You must discontinue coverage for your former spouse and any dependents that become ineligible (e.g., stepchildren), and you may remove any dependents that will be added to your former spouse's plan.§ You may enroll or add coverage for yourself or any eligible dependents that are no longer covered under your former spouse's plan. You also may change coverage to another Plan option.†	You must discontinue coverage for your former spouse and any dependents that become ineligible (e.g., stepchildren), and you may remove any dependents that will be added to your former spouse's plan. You may enroll or add coverage for yourself or any eligible dependents that are no longer covered under your former spouse's plan. You may also change coverage to another Plan option.	You may enroll or increase election if losing coverage under spouse's health plan; may drop or decrease election.¶	You may enroll or increase election if event increases dependent care expenses or triggers eligibility or if you lose coverage under spouse's Dependent Care FSA; may drop or decrease election if event changes dependent eligibility (e.g., if child now resides with ex-spouse) or lowers dependent care expenses.	Date of qualifying event. (Plan coverage terminates as of the date of event for any former spouse or dependent that becomes ineligible.) Adding/removing eligible dependents: Date of qualifying event.

HEALTH PLAN	DENTAL PLAN (Traditional & Medallion)	HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)*, §§	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)*, §§	EFFECTIVE DATE
You have the opportunity to change your benefits if you end a domestic partnership# . . .				
You must discontinue coverage for your former domestic partner and any dependents that become ineligible (e.g., stepchildren or partners' children). You may enroll if you lost coverage under your former domestic partner's plan. You may add coverage for any eligible dependents that are no longer eligible for coverage under your former domestic partner's plan or for whom you are required to provide coverage pursuant to a Qualified Medical Child Support Order. If your domestic partner (or his or her child) was your tax dependent, then you also may change coverage to another Plan option.†	You must discontinue coverage for your former domestic partner and any dependents that become ineligible (e.g., partner's children). You may enroll if you lost coverage under your former domestic partner's plan. You may add coverage for any eligible dependents that are no longer eligible for coverage under your former domestic partner's plan or for whom you are required to provide coverage pursuant to a Qualified Medical Child Support Order. If your domestic partner (or his or her child) was your tax dependent, then you also may change coverage to another Plan option.	You may drop or decrease your election if your domestic partner and any dependents cease to be a qualified dependent for the Health Care FSA as a result of the end of domestic partnership.¶	You may enroll or increase election if event increases dependent care expenses (e.g., if you have to enroll your child in day care as a result of the loss of child care provided by your former domestic partner). You may drop or decrease your election if your domestic partner and any dependents cease to be a qualified dependent for the Dependent Care FSA as a result of the of domestic partnership.	Date of qualifying event. (Any claims incurred on or after the date of ineligibility by the domestic partner will not be paid by the plan.) Adding/removing eligible dependents: Date of qualifying event.
You have the opportunity to change your benefits if your eligible dependent passes away . . .				
You must drop the deceased from coverage. You may enroll or add coverage for yourself or any eligible surviving dependents that are no longer covered under the deceased's plan. You also may change coverage to another Plan option.†	You must drop the deceased from coverage. You may enroll or add coverage for yourself or any eligible dependents that are no longer covered under the deceased's plan. You also may change coverage to another Plan option.	You may enroll or increase election if you lose coverage under an opposite-sex spouse's plan. You may drop or decrease election if the deceased was an eligible dependent for the Health Care FSA.¶	You may enroll or increase election if event increases dependent care expenses or triggers eligibility or if you lose coverage under an opposite-sex spouse's plan. You may drop or decrease election if event changes dependent eligibility (e.g., if you lose custody of stepchild) or lowers dependent care expenses (e.g., if same-spouse or domestic partner was a tax dependent requiring dependent care services for self).	Date of qualifying event.
You have the opportunity to change your benefits if you have a new child (by birth, adoption, or placement for adoption) . . .				
You may enroll or add coverage for your spouse or domestic partner and any newly eligible dependents. You also may change coverage to another Plan.† If you and/or your eligible dependents gain coverage under a spouse's or domestic partner's plan, you may discontinue coverage for yourself and/or any affected dependents.§	You may enroll or add coverage for your spouse or domestic partner and any newly eligible dependents. You also may change coverage to another Plan option. If you and/or your eligible dependents gain coverage under a spouse's or domestic partner's plan, you may discontinue coverage for yourself and/or any affected dependents.	You may enroll or increase election.¶	You may enroll or increase election if event increases dependent care expenses; may drop or decrease election if event changes eligibility or decreases expenses (e.g., if spouse stops working to care for other children in day care).	Date of qualifying event.

HEALTH PLAN	DENTAL PLAN (Traditional & Medallion)	HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)*, §§	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)*, §§	EFFECTIVE DATE
You have the opportunity to change your benefits if your dependent is no longer eligible for benefits under the University Plan (e.g., child reached the age at which coverage is no longer available) . . .				
You must discontinue coverage for your ineligible spouse, domestic partner, or dependent.	You must discontinue coverage for your ineligible spouse, domestic partner or dependent.	You may drop or decrease election if the spouse, domestic partner, or dependent was an eligible dependent for the Health Care FSA.¶	You may drop or decrease election if the spouse, domestic partner, or dependent was an eligible dependent for the Dependent Care FSA.¶	Date of qualifying event. (Plan coverage terminates as of the date of ineligibility. Children turning 26 continue coverage through the end of the calendar month.)
You have the opportunity to change your benefits if you experience a change in employment status that impacted your eligibility for benefits (e.g., retirement, commencing or returning from a leave of absence in excess of 30 days, termination of employment, transfer to the University from another affiliated employer) . . .				
If you have become newly eligible: You may enroll for coverage. If you are no longer eligible: Your coverage is canceled effective on the last date of the pay period in which you lost eligibility. COBRA coverage may be available to you and your eligible dependents. If you retire##, you may change or drop your medical coverage. If you continue coverage, your premiums will be paid on an after-tax basis. COBRA coverage may be available to you and your eligible dependents.	If you have become newly eligible: You may enroll for coverage. If you are no longer eligible: Your coverage is canceled effective on the last date of the pay period in which you lost eligibility. COBRA coverage may be available to you and your eligible dependents. If you retire##, you may change or drop your dental coverage. If you continue coverage, your premiums will be paid on an after-tax basis. COBRA coverage may be available to you and your eligible dependents.	If you have become newly eligible: You may enroll in a Health Care FSA or Dependent Care FSA. If you are no longer eligible, your FSA participation stops as of the date of your change to an ineligible status. COBRA coverage may be available to you and your eligible dependents. You will have 90 days from the date you became ineligible to submit eligible expenses incurred prior to the FSA cancellation date.	If you have become newly eligible: You may enroll in a Health Care FSA or Dependent Care FSA. If you are no longer eligible, your FSA participation stops as of the date of your change to an ineligible status. You will have until April 30 following the end of the plan year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.	Newly eligible: Date of qualifying event. No longer eligible: Refer to previous appropriate column.
You have the opportunity to change your benefits if your eligible dependent experiences a qualifying election change event under his or her own employer's cafeteria plan (e.g., change in employment status, HIPAA special enrollment right, significant cost increase or curtailment of coverage, etc.) . . .**				
You may make corresponding changes permitted by Cafeteria Plan tax regulations, as determined by the Office of Total Rewards.	You may make corresponding changes permitted by Cafeteria Plan tax regulations, as determined by the Office of Total Rewards.	You may make corresponding changes permitted by Cafeteria Plan tax regulations, as determined by the Office of Total Rewards.	You may make corresponding changes permitted by Cafeteria Plan tax regulations, as determined by the Office of Total Rewards.	Date of qualifying event.
You have the opportunity to change your benefits if you become enrolled as an adult child under your parent's employer's group health Plan during an annual Open Enrollment period, HIPAA special enrollment period, or as a result of your parent experiencing a qualifying election change event under his or her own employer's Cafeteria Plan . . .				
You may discontinue coverage.	No change permitted.	No change permitted.	No change permitted.	Date of qualifying event.
You have the opportunity to change your benefits if you experience a significant change in the cost of dependent care and the cost change is imposed by a dependent care provider who is not your relative . . .				
No change permitted.	No change permitted.	No change permitted.	You may enroll or increase election if the cost significantly increases. You may drop or decrease election if the cost significantly decreases.	Date of qualifying event.

HEALTH PLAN	DENTAL PLAN (Traditional & Medallion)	HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)*, §§	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)*, §§	EFFECTIVE DATE
You have the opportunity to change your benefits if you or your former spouse is required to provide coverage for a dependent by legal judgment or court order (e.g., Qualified Medical Child Support Order) . . .				
You may enroll and add coverage for your eligible dependent if the order requires you to provide coverage. You also may change coverage to another Plan option.† If the order requires another individual to provide coverage (e.g., former spouse or child's other parent), you may drop coverage for the child.	You may enroll and add coverage for your eligible dependent if the order requires you to provide coverage. You also may change coverage to another Plan option. If the order requires another individual to provide coverage (e.g., former spouse or child's other parent), you may drop coverage for the child.	You may enroll or increase election if the order requires you to provide coverage.	You cannot make any changes to your Dependent Care FSA.	Date required by court order or date order is determined by Plan Administrator to be qualified, whichever is later.
You have the opportunity to change your benefits if you, your current or former spouse (or his or her child) who is a tax dependent, or current domestic partner (or his or her child) who is a tax dependent, or your child changes coverage from another employer's plan during the other employer's open enrollment period that is different than the University's Open Enrollment period . . .				
You may enroll or add coverage for your affected spouse, domestic partner, and eligible dependents who lose coverage under the other plan. You also may change coverage to another Plan option.† You may discontinue coverage for yourself and any dependents that gain coverage through the other employer's plan.§	You may enroll or add coverage for your affected spouse, domestic partner, and eligible dependents who lose coverage under the other plan. You also may change coverage to another Plan option. You may discontinue coverage for you and any dependents that gain coverage through the other employer's plan.	You may not make any changes to your Health Care FSA.	You may increase your contribution amount if your spouse decreases coverage. If your spouse increases coverage, you may decrease your coverage.¶	Date of qualifying event.
You have the opportunity to change your benefits if your current domestic partner (or his or her child) who is not a tax dependent, changes coverage from another employer's plan during their employer's open enrollment period that is different than the University's Open Enrollment period . . .**				
You may add coverage for your affected domestic partner and eligible dependents on an after-tax basis. You may discontinue coverage for any dependents who were receiving University coverage on an after-tax basis that gain coverage through the other employer's plan.§	You may add coverage for your affected domestic partner and eligible dependents on an after-tax basis. You may discontinue coverage for yourself and any dependents that gain coverage through the other employer's plan.	No change allowed.	No change allowed	Date of qualifying event.
You have the opportunity to change your benefits if you or your eligible dependents lose eligibility for other employer group health plan coverage, governmental health insurance, or nongovernmental health insurance through no fault of your own, exhaust COBRA coverage, or another employer ceases contributions toward health insurance for you or your eligible dependents . . .				
You may enroll for coverage for yourself, your spouse, your domestic partner or your children who were affected. You also may change coverage to another Plan option.†	You may enroll for coverage yourself, your spouse, your domestic partner or your children who were affected. You also may change coverage to another Plan option.	You may enroll or increase elections to reflect loss of eligibility for other Health Care FSA.	You may enroll or increase election if you or your spouse or tax dependent loses eligibility for other employer's Dependent Care FSA. You may drop or decrease election to reflect loss of eligibility for coverage (e.g., if spouse stops working).¶	Date of qualifying event.

HEALTH PLAN	DENTAL PLAN (Traditional & Medallion)	HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)*, §§	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)*, §§	EFFECTIVE DATE
You have the opportunity to change your benefits if you start or return from an FMLA or military leave . . .				
If you start an FMLA or military leave, you may cancel your coverage. Upon returning from an FMLA or military leave, you may reinstate your prior coverage. If you have experienced another election change event while on leave or have been on leave in excess of 30 days, you may make an election change in accordance with the rules for that event.	If you start an FMLA or military leave, you may cancel your coverage. Upon returning from an FMLA or military leave, you may reinstate your prior coverage. If you have experienced another election change event while on leave or have been on leave in excess of 30 days, you may make an election change in accordance with the rules for that event.	If you have a Health Care FSA at the start of an FMLA or military leave, you may cancel your Health Care FSA. If you are returning from an FMLA or military leave and had a Health Care FSA, you may reinstate your prior election amount.¶,†† If you have experienced another election change event while on leave or have been on leave in excess of 30 days, you may make an election change in accordance with the rules for that event.	If you have a Dependent Care FSA at the start of an FMLA or military leave, you may cancel your Dependent Care FSA.¶,†† You must cancel your Dependent Care FSA if your FMLA leave will exceed two weeks (this is not required for military leaves). If you are returning from an FMLA or military leave and had a Dependent Care FSA, you may reinstate your prior election amount.# If you have experienced another election change event while on leave or have been on leave in excess of 30 days, you may make an election change in accordance with the rules for that event.	Date of qualifying event.
You have the opportunity to change your benefits if you or your eligible dependents enroll in Medicaid or Medicare . . .				
Cancel or reduce coverage for individual who enrolled in Medicaid or Medicare.§	Cancel or reduce coverage for individual who enrolled in Medicaid or Medicare.§	You may drop or decrease election if the affected individual was an eligible dependent for the Health Care FSA.	No change is permitted.	Date of qualifying event.
You have the opportunity to change your benefits if you or your eligible dependents lose entitlement to Medicaid or a state children's health insurance program . . .				
Enroll or increase coverage for yourself, your spouse, your domestic partner, or your children (whomever lost the entitlement). You also may change coverage to another Plan option.†	Enroll or increase coverage for yourself, your spouse, your domestic partner, or your children (whichever lost the entitlement).	No change is permitted.	No change is permitted.	Date of qualifying event.
You have the opportunity to change your benefits if you or your eligible dependents become eligible for state premium assistance from Medicaid or a state children's health insurance program . . .				
Enroll or increase coverage for yourself, your spouse, your domestic partner or your children (whomever gained the entitlement). You also may change coverage to another Plan option.† Note: While receiving premium assistance, enrollment in a high deductible health plan is prohibited.	No change is permitted.	No change is permitted.	No change is permitted.	Date of qualifying event.

HEALTH PLAN	DENTAL PLAN (Traditional & Medallion)	HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)*, §§	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)*, §§	EFFECTIVE DATE
You have the opportunity to change your benefits if you or your eligible dependents enroll in or lose coverage in a Qualified Health Plan (QHP) through a public health insurance exchange/marketplace . . .				
You may cancel coverage for the individual(s) who enrolled in (or intend(s) to enroll in) QHP coverage. QHP coverage must be effective immediately following cancellation of University Health Plan coverage. No change is permitted if you or your dependents lose QHP coverage.¶¶	No change is permitted.	No change is permitted.	No change is permitted.	N/A
You have the opportunity to change your benefits if you experience a significant cost change in the premium for medical coverage . . .				
Cost Increase: You may change coverage to another plan option or discontinue coverage if you elect coverage through another employer's plan. Cost Decrease: You may elect new coverage or change coverage to another plan.	No change is permitted.	No change is permitted.	No change is permitted.	Date of qualifying event.

* *Any request to change an FSA must be consistent with the qualifying event (e.g., if you have a Health Care FSA, you may increase or decrease your contribution if you have a loss of coverage under your spouse's or former spouse's plan. If you have a Dependent Care FSA, you may increase or decrease your contribution if your qualifying event results in a change in your dependent care expenses).*

† *If you enroll for coverage under the YOUR HSA-Eligible Plan as the result of a qualifying event, you may be eligible to contribute to an HSA. However, the HSA contribution maximums are prorated if you will be covered by the YOUR HSA-Eligible Plan for less than 12 months of the current calendar year.*

§ *If you terminate coverage under the YOUR HSA-Eligible Plan as the result of a qualifying event, any contributions you make to your HSA via payroll deduction will stop on the effective date.*

¶ *When changing due to a qualifying event, the FSA annual election cannot be reduced below the amount of payroll contribution already deduction or claims submitted for the calendar year if it would result in a negative balance, and the change must be consistent with the qualifying event.*

\# *For rules regarding the eligibility of a domestic partner and/or their dependents, please refer to the University of Rochester certification of domestic partner status form at www.rochester.edu/totalrewards (go to Benefits forms and summaries and select Domestic partner forms), or you may request a copy from the Office of Total Rewards by phone (585) 275-2084 or email (totalrewards@rochester.edu). In order to add a qualified domestic partner for coverage, the University of Rochester certification of domestic partner status form, along with a completed Qualifying Event Change form, along with a copy of your legal domestic partner certificate/agreement, must be submitted to and approved by the Office of Total Rewards.*

** *If the dependent that experiences an election change event with their own employer is not eligible for pre-tax benefits when covered as a dependent through the University (e.g., your domestic partner who is not your tax dependent), then the election change options are even more restrictive under federal tax law. In that circumstance, you can only make election changes with respect to other dependents who are also not eligible for pre-tax benefits; you cannot make any election changes with respect to your own coverage or coverage for your dependents who are eligible for pre-tax benefits.*

†† *If your account lapsed during your leave, you may elect coverage at the prior level or at a prorated level (the prorated level is your elected annual FSA contribution amount, adjusted for the period of time you were out, minus any reimbursements you have received year-to-date). In other words, you can elect to keep the same total annual contribution (per-pay-period deductions will be adjusted) or to keep the same per-pay-period deduction and reach a lower annual goal due to the time you were on leave.*

§§ *A newly elected Health Care FSA or Dependent Care FSA will be effective the first day of the pay period following the date the enrollment form is submitted (if submitted before any applicable administrative processing deadline), or the date of hire, appointment, or change to eligible status, whichever is later. A newly elected Health Savings Account will be effective the first day of the pay period following the date the account is established, the first day of the pay period following the date the enrollment form is submitted (if submitted before any applicable administrative processing deadline), the date of the appointment or change to eligible status, or the first day of the calendar month following or coinciding with the effective date of YOUR HSA-Eligible Plan Coverage, whichever is latest.*

¶¶ *Non-Medicare-eligible retirees or non-Medicare-eligible dependents of retirees who lose or drop QHP coverage may add University Health Care Plan coverage. Current employees and their dependents are not permitted to make such change.*

\#\# *Retiree benefits may apply. Contact the Office of Total Rewards for eligibility.*

This Guide summarizes the University of Rochester's Health Care Plans, Dental Plans, Lifestyle Management Plan, Employee Assistance Program, and Flexible Spending Accounts effective January 1, 2022. The University reserves the right to modify, amend, or terminate the plans at any time, including actions that may affect coverage, cost-sharing, or covered benefits, as well as benefits that are provided to current and future retirees.

Appendix B

Coverage During Leave of Absence

	Health Care and Dental Plans	Flexible Spending Accounts (FSAs)*	Health Savings Account (HSA)†
If you become disabled (non-work-related illness or injury) . . .	Coverage continues: • While you are receiving benefits under the Sick Leave Plan for Short-Term Disability • While you are receiving benefits under the University of Rochester Long-Term Disability Plan (LTD) You continue to pay your normal share of the premium(s)‡. If you are on LTD and receiving or become eligible for Medicare: Medicare will become the primary payer for health care expenses for individuals under the University Health Care Plan who are or become eligible for Medicare. The University will be secondary.	Health Care FSA: FSA participation continues while you are receiving payments under the Sick Leave Plan for Short-Term Disability paid through the University of Rochester payroll. Dependent Care FSA: Participation is terminated. You will have until April 30 following the end of the plan year to submit expenses incurred while you were working. The amount available for reimbursement is limited to the amount credited to your Dependent Day Care FSA, less any reimbursements.	HSA participation continues while you are receiving payments under the Sick Leave Plan for Short-Term Disability paid through the University of Rochester payroll. Note: HSA contributions† via payroll deductions stop as of the effective date that you are approved for LTD benefits. Please refer to the section, "If you terminate or change to an ineligible status."
If you are on an unpaid leave of absence or temporary layoff . . .	Coverage continues unless you sign a form canceling coverage.‡	FSA participation stops as of the effective date of the unpaid leave or temporary layoff. When you return to work in a benefit-eligible position, if you wish to elect an FSA, you must enroll within 60 days of your return. Health Care FSA: You must elect COBRA continuation coverage and remit after-tax contributions to submit eligible expenses incurred during an unpaid leave of absence or temporary layoff. Otherwise, you will have 90 days from the effective date of the unpaid leave or temporary absence to submit eligible expenses incurred prior to the FSA cancellation date. FMLA: For the time period covered by an unpaid FMLA Leave, or New York Paid Family Leave you have the option to continue a Health Care FSA. You will need to contact the Office of Total Rewards to set up billing and will need to pay your share of contributions on an after-tax basis. Dependent Care FSA: You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.	HSA contributions† via payroll deduction will stop as of the effective date of the unpaid leave or temporary layoff. When you return to work in a benefit-eligible position, if you wish to elect an HSA, you must make a new contribution election. You may make your own tax-deductible HSA contributions during leave or temporary layoff.

	Health Care and Dental Plans	Flexible Spending Accounts (FSAs)*	Health Savings Account (HSA)†
If you are on an indefinite layoff . . .	Coverage continues if you have two or more years of service, unless you sign a form canceling coverage.‡ If you have less than two years of service, your Plan coverage is canceled effective on the last day of the pay period in which your indefinite layoff occurs. Please refer to the section, "If you terminate or change to an ineligible status."	FSA participation stops as of the effective date of the indefinite layoff. If you return to work in a benefit-eligible position and wish to elect an FSA, you must enroll within 60 days of your return. Health Care FSA: You must elect COBRA continuation coverage, and remit after-tax contributions, to submit eligible expenses incurred during layoff. Otherwise, you will have 90 days from the effective date of the indefinite layoff to submit eligible expenses incurred prior to the FSA cancellation date. Dependent Care FSA: Since Dependent Care FSAs are established to allow the employee to work, Dependent Care FSAs are suspended during an unpaid FMLA Leave. You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.	HSA contributions† via payroll deduction will stop as of the effective date of the indefinite layoff. If you return to work in a benefit-eligible position and you wish to elect an HSA, you must make a new contribution election. You may make your own tax-deductible HSA contributions during leave or temporary layoff.
If you are on a military leave . . .	Your active coverage continues for up to 12 months unless you sign a form canceling coverage. When coverage stops, you will be sent a separate document that explains your rights to continue coverage for an additional 18 months under COBRA. When you return to work at the University, the University Health Care and Dental Plans will not be required to cover injuries or illnesses that are determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of services in the armed forces. Those will be covered by the uniformed service. However, there will be no waiting periods or pre-existing condition limitations upon your return to work.	FSA participation stops as of the effective date of your military leave. When you return to work in a benefit-eligible position, if you wish to elect an FSA, you must enroll within 60 days of your return. Health Care FSA: You may continue coverage for up to 12 months. You will need to contact the Office of Total Rewards to set up billing and will need to pay your share of contributions on an after-tax basis. You will have 90 days from the effective date of your cancellation to submit eligible expenses incurred prior to the FSA cancellation date. You may take a taxable distribution of all or a portion of the funds remaining in your Health Care FSA or you may elect COBRA/USERRA continuation coverage and remit after-tax contributions to submit eligible expenses incurred during your military leave. You will need to complete an FSA Qualified Reservist Distribution Form (available from the Office of Total Rewards) to request a distribution. The maximum amount available for distribution is the actual amount in the account (i.e., contributions minus reimbursements). Dependent Care FSA: You will have until April 30 following end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.	HSA contributions† via payroll deduction will stop effective the date of the military leave. When you return to work in a benefit-eligible position, if you wish to elect an HSA, you must make a new contribution election. You may make your own tax-deductible HSA contributions during military leave.

	Health Care and Dental Plans	Flexible Spending Accounts (FSAs)*	Health Savings Account (HSA)†
If you fail to pay premiums or contributions . . .	Your coverage is canceled effective the last day of the period for which premiums were paid. COBRA is not available.	Your participation terminates effective the last day of the period for which contributions were made. Health Care FSA: COBRA is not available. You will have 90 days from the effective date of the termination to submit eligible expenses incurred prior to the cancellation date. Dependent Care FSA: You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.	You maintain your HSA and may make after-tax contributions directly to the trustee/custodian.
If you are on Workers' Compensation . . .	Coverage continues as long as you remain an employee (and if your claim extends beyond 6 months, you are receiving LTD benefits). Premiums will be deducted from your paycheck while you are receiving a paycheck from the University of Rochester. Premiums will not be deducted from the checks issued by Gallagher Basset; however, premiums for that time period will be deducted from your University paycheck upon your return to work unless you enroll in quarterly billing to pay your share of your health and/or dental premiums.	FSA participation continues for the first seven days while you are receiving payments under the Workers' Compensation Plan paid through the University of Rochester payroll. When you return to work in a benefit-eligible position, if you wish to elect an FSA, you must enroll within 60 days of your return. Health Care FSA: After the seven days, you must elect COBRA continuation coverage and remit after-tax contributions to submit eligible expenses incurred during this time period. You will have 90 days from the effective date of your approved Workers' Compensation claim to submit eligible expenses incurred prior to the FSA cancellation date. Dependent Care FSA: Since Dependent Care FSAs are established to allow the employee to work, Dependent Care FSAs are suspended. You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.	HSA participation continues for the first seven days while you are receiving payments under the Workers' Compensation Plan paid through the University of Rochester payroll. After the seven days, HSA contributions via payroll deduction will stop as of the effective date of your approved Workers' Compensation claim. When you return to work in a benefit-eligible position, if you wish to elect an HSA, you must make a new contribution election. You may make your own tax-deductible HSA contributions during leave.
If you terminate or change to an ineligible status . . .	Your Plan coverage will be canceled effective on the last day of your current pay period in which you are benefits-eligible. When coverage stops, you will be sent a separate document that explains your rights under COBRA continuation coverage. Coverage for your dependents ends on the earlier of the date that your coverage ends or the date that your dependent no longer qualifies as an eligible dependent.	Your FSA participations stops as of your termination date or change to an ineligible status. When coverage stops, you will be sent a separate document that explains your rights under COBRA continuation coverage for the Health Care FSA. Health Care FSA: You will have 90 days from your date of termination or change to an ineligible status to submit eligible expenses incurred prior to the FSA cancellation date. Dependent Care FSA: You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.	HSA contributions† via payroll deduction stop as of your date of termination or change to an ineligible status. However, your HSA is solely owned by you and will continue with you even after you are no longer employed by the University or if you otherwise become ineligible for benefits. This means that you can continue to make contributions to your HSA as long as you are enrolled in HSA-eligible coverage, and you will continue to have access to the funds in your HSA. Your HSA will move from the University group to an individual account within the bank, so please contact HSA Bank for details.

	Health Care and Dental Plans	Flexible Spending Accounts (FSAs)*	Health Savings Account (HSA)†
If you change to a Time-as-Reported (TAR) status . . .	Health Care Plan: Coverage continues if you are considered a full-time employee per the Employer Shared Responsibility Mandate of the Patient Protection and Affordable Care Act (PPACA). See the University's Measurement and Stability Periods Policy on the Office of Total Rewards website for additional information. If you are not considered a full-time employee per the PPACA, your health coverage will be canceled effective on the last day of your current pay period in which you are benefits-eligible. Dental Plan: Coverage will be canceled effective on the last day of your current pay period in which you are benefits-eligible. When coverage stops, you will be sent a separate document that explains your rights under COBRA continuation coverage.	Your FSA participations stops as of your transfer date. When cover- age stops, you will be sent a separate document that explains your rights under COBRA continuation coverage for the Health Care FSA. Health Care FSA: You will have 90 days from your transfer date to submit eligible expenses incurred prior to the FSA cancellation date. Dependent Care FSA: You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.	If you are considered a full-time employee per the PPACA, your HSA contributions via payroll deductions will continue. If you are not considered a full-time employee per the PPACA, HSA contributions† via payroll deduction stop as of your transfer date. However, your HSA is solely owned by you and will continue with you even after you are no longer employed by the University or if you otherwise become ineligible for benefits. This means that you can continue to make contributions to your HSA as long as you are enrolled in HSA-eligible coverage and you will continue to have access to the funds in your HSA. Your HSA will move from the University group to an individual account within the bank, so please contact your HSA Bank for details.
When you retire§ . . .	Eligibility for coverage continues. If you wish to change or waive health care or dental coverage, you must complete a form to cancel coverage. If you (or a covered dependent) are eligible for Medicare and you wish to enroll in Health Care Plan coverage, you will need to contact Via Benefits at 1-833-945-1110 to speak with an advisor. Post-Retirement Health and Dental Cost-Sharing: The University's share of the health care and dental premiums varies depending on the Post-Retirement Level of the faculty or staff member‡. To view costs and subsidy amounts, visit www.rochester.edu/totalrewards. Select Employment Changes and then select Retirement.	Your FSA participation stops on the date of your retirement. When coverage stops, you will be sent a separate document that explains your rights under COBRA continuation coverage for the Health Care FSA. Health Care FSA: You will have 90 days from the date of your retirement to submit eligible expenses incurred prior to the FSA cancellation date. Dependent Care FSA: You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.	HSA contributions† via payroll deduction stop when you retire. However, your HSA is solely owned by you and will continue with you even after you retire. This means that you can continue to make contributions to your HSA as long as you are enrolled in HSA-eligible coverage, and you will continue to have access to the funds in your HSA. Your HSA will move from the University group to an individual account within the bank, so please contact your HSA Bank for details.
If you die . . .	Health Care Plan¶: (1) And you had more than five years of service and were eligible to retire, your family members' health coverage will continue at the active cost-sharing for one year if your surviving spouse/domestic partner and/or eligible children are non-Medicare-eligible. After one year: After one year, your family members' cost-sharing will be equal to the full premium of the plan they are enrolled in. Certain legacy eligibility/subsidies may exist; please contact the Office of Total Rewards for more information. Your family members' cost-sharing will be equal to the full premium of the plan they are enrolled in. (2) And you had more than five years of service but were not eligible to retire, your family members' health coverage will continue at the active cost-sharing for one year. After one year, your non-Medicare-eligible family members will be offered 36 months of COBRA continuation coverage. (3) And you had fewer than five years of service, your family members will be offered 36 months of COBRA continuation coverage in the health care plan. Dental Plan: Your family members will be offered 36 months of COBRA continuation coverage in the Dental Plan (regardless of your length of service or retirement eligibility).	Your FSA participation will end as of the date of your death. Health Care FSA: Any claims incurred prior to your death must be submitted for reimbursement within 90 days. Your family members may elect COBRA on the Health Care FSA and remit after-tax contributions for the remainder of the Plan Year; this will allow them to receive reimbursement for claims they incur after your death. Dependent Care FSA: Your family members will have until April 30 following the end of the Plan Year to submit eligible expenses incurred prior to your death. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.	If your spouse is the primary beneficiary, your spouse will have the option to transfer the balance from your account into a new account in his/her name and continue to use the funds for tax-free, qualified expenses. If your spouse meets the eligibility requirements for the new account, he/she may contribute to the HSA. If your primary beneficiary is not your spouse, all funds in your HSA will be distributed to your beneficiary, and your HSA will be closed. Note: The distributed funds will be taxable. If you do not have a beneficiary, consult with your legal advisor on how your HSA will be affected.

	Health Care and Dental Plans	Flexible Spending Accounts (FSAs)*	Health Savings Account (HSA)†

* *If you return to work within 30 days, your prior elections will automatically be reinstated upon your return.*

† *Only faculty and staff who are enrolled in an HSA-Eligible Plan and satisfy certain other requirements can make contributions to an HSA. If you are enrolled in an HSA-Eligible Plan and eligible to contribute to an HSA, you can contribute directly to your HSA, outside of payroll deductions, at any time, as long as you do not exceed your annual maximum. You also can change your HSA election (payroll deductions) anytime throughout the year.*

‡ *Employees and retirees enrolled in coverage through the University and not receiving paychecks from the University will be billed for their share of the health and/or dental premiums on a quarterly basis. Non-Medicare-eligible employees and retirees must continue to pay their share of the premium for the Health Care Plan and Dental Plan coverage to continue coverage through the University. If the University does not receive payment for the coverage, the coverage will be terminated on the last day of the month in which the premium has been paid in full and notification of the coverage cancellation will be sent to the home address from the University. Employees and retirees whose coverage has been canceled due to non-payment will not be eligible to re-enroll in Health Care Plan or Dental Plan coverage until the next Open Enrollment period and until any premiums past due are paid to the University. Employees and retirees returning to work with an outstanding balance will be subject to arrears billing. The employee's share of the premium is based on their salary, University service and full-time/part-time status prior to the start of the layoff.*

§ *The University reserves the right to change or terminate plans at any time, including benefits provided to current and future retirees.*

¶ *For information on Medicare-eligible plans offered through Via Benefits, please visit my.viabenefits.com*

The following definitions apply for this Appendix B:

- *Layoff (indefinite)*—An indefinite suspension of University employment because of reduction of staff or elimination of a position for more than four months or for unspecified duration, not over one year.
- *Layoff (temporary)*—A layoff that equates to a temporary suspension of University employment because of reduction of staff or elimination of a position with the expectation of return to work within four months of the day the layoff begins.
- *Leave of Absence*—An approved absence which does not end but does change the appointment relationship. Leave may be for research or study, to permit a visiting appointment elsewhere, for personal reasons, or for disability.

UNIVERSITY of ROCHESTER