YOUR HSA-Eligible Plan Guide

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www.rochester.edu/benefits

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. This document provides only a summary of the main features of the plans. Detailed information on the benefit plans is available on the Benefits website www.rochester.edu/benefits. A paper copy of this information is available for free from the Benefits Office. This booklet only provides a brief summary of the plan terms, in the event of a conflict between this booklet and the official plan document or SPD, the plan document or SPD shall be controlling. The University of Rochester believes that the FSA and EAP Plans are “grandfathered health plans” under the Patient Protection and Affordable Care Act or health care reform).
How to Choose a Plan

Choose and Use Your 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, we encourage you to take an active role in managing your health by maintaining a healthy lifestyle, choosing providers within the Accountable Health Partners provider panel or your Third Party Administrator’s (Aetna or Excellus) National Network when appropriate, establishing a relationship with a Primary Care Physician if you haven’t already, evaluating your health care choices when care is needed and using the various resources available to you as a University employee.

Enrollment Checklist

- **Learn about Your Options and Choose a Plan:** Utilize the tools and resources available to learn how the University’s Health Care Plans work and to determine which plan might be best for you and your dependents. Make use of the following:
  - **YOUR HSA-Eligible and YOUR PPO Plan Booklets:** Overview of how the Plans work.
  - **Tax-Advantaged Account Booklet:** Details about how the Health Savings Account and Flexible Spending Accounts operate, eligibility requirements and how you might benefit from electing an account.
  - **2016 Health Plans Comparison Chart:** Compares the YOUR PPO Plan and YOUR HSA-Eligible Plan, shows how services are covered under each Plan.
  - **2016 Health Program Guide:** Provides detailed, in-depth information regarding the University’s Health Program and integrated health system.
  - **ALEX:** Online benefits decision tool designed to assist employees in understanding various benefit options and provide assistance in making educated benefit related decisions. Available on the Benefits Video page at: https://www.rochester.edu/working/hr/benefits/video/.
  - **YOUR PPO Plan, YOUR HSA-Eligible Plan, Flexible Spending Accounts and the Health Savings Account videos:** Short videos designed to provide a brief overview of the University Health Care Plans and the tax-advantaged accounts available to eligible employees.
• **Choose a Third-Party Administrator**: When you elect a health care plan, you need to choose which Third-Party Administrator (TPA) will administer your plan—either Aetna or Excellus BlueCross BlueShield. You may want to consider the national network availability when choosing your TPA. In addition to the Accountable Health Partners providers, you have the option to use participating providers from within the rest of your TPA’s National Network.

• **Enroll for Benefits**: You can enroll online in HRMS during the annual open enrollment period or, if you are a new hire and are enrolling for the first time, you can enroll in HRMS within 30 days of your hire or appointment date.

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**Factors to Consider**

**Who Will Be Covered on Your Plan?**
The coverage levels available to you for health care are:

- Single
- Employee and Child(ren)
- Employee and Spouse or Domestic Partner
- Family

Review the Health Care Program Benefit Eligible Dependents Definition in the appendix or on the Benefits website (www.rochester.edu/benefits) for additional information regarding eligible dependents.

**Know Your Expenses**
Review your medical claims for the past year—if you had coverage through the University, you can use the Aetna or Excellus member tools to view your claims history:

- Aetna: www.aetna.com
- Excellus: www.excellusbcbs.com/ur

**Do You Want a Tax-Advantaged Account for Your Out-of-Pocket Qualified Expenses?**
A Health Savings Account allows eligible individuals to pay for qualified medical, dental and vision expenses with pre-tax payroll deductions.

- The YOUR HSA-Eligible Plan satisfies the IRS’s requirements pertaining to a High Deductible Health Plan, which is one of several eligibility requirements that must be met before an eligible individual can contribute to a Health Savings Account.

- Review the Tax-Advantaged Accounts Booklet for information regarding eligibility, benefits, savings, etc.
Important Components of Your Plan

Preferred Provider Organization (PPO)
A PPO is a health care benefit plan that allows those covered to receive care by network and non-network providers. In many cases those covered will receive a higher level of benefits for using a network provider in addition to the lower fees charged by the provider. The Provider will automatically bill the Plan, and patients are not billed for charges higher than the amount allowed by the applicable tier administrator (either Accountable Health Partners, Aetna or Excellus).

Accountable Health Partners (AHP)
A provider panel made up of University of Rochester Medical Faculty Group providers and carefully selected community partners created to improve the health of the University’s employees and covered dependents. The University is working with Accountable Health Partners providers (a subset of the Aetna and Excellus National Networks) as a choice and opportunity for employees to experience lower cost-sharing under your plan—lower deductible, coinsurance and out-of-pocket maximum.

Visit the Accountable Health Partners website at: www.ahpnetwork.com or call AHP customer service at 1-888-457-7463 for additional information about the benefits of seeking care from an AHP provider and for a full list of Accountable Health Partners providers.

Third-Party Administrator (TPA)
A TPA processes health care claims and provides additional services for members. The University offers the choice of two TPAs to administer its health care plans: Aetna or Excellus BlueCross BlueShield.

Both Aetna and Excellus BlueCross BlueShield offer a national network of participating providers. Utilize the Aetna Doc Find at www.aetna.com and select Find a Doctor. Excellus members can access Excellus’s provider search tool by visiting www.excellusbcbs.com/ur and select Find a Doctor or Hospital.

Designation of Primary Care Providers and/or OB/GYN
Some of the plan options require or permit the designation of a primary care provider. You have the right to designate any primary care provider who participates in your TPA’s network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator at 1-585-275-2084 or the TPA (Aetna or Excellus).

You do not need prior authorization from your TPA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a preapproved
treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator at 1-585-275-2084 or the TPA (Aetna or Excellus).

**Annual Deductible**
The amount of out-of-pocket expenses that you must pay for health and pharmacy services before the Plan begins to pay benefits for covered services. Preventive services are covered at 100% throughout the year and are not subject to the deductible; see the 2016 Health Program Guide for additional information regarding coverage for preventive services.

**For example:** If you have single coverage and receive services from AHP providers, upon satisfying the $1,300 deductible, the Plan will pay 90% of your covered health care costs if you continue to receive services from AHP providers. You would be responsible for the remaining 10% of your covered health care costs. All medical and pharmacy expenses are subject to the deductible—with the exception of preventive services, which are covered at 100%.

If you are enrolled in the YOUR HSA-Eligible Plan with one or more dependents, the family deductible would apply. Therefore, if you and/or your covered family members seek services from AHP providers, your family would need to meet the family deductible of $2,600 before anyone on the Plan would move to the coinsurance phase. Once satisfying the family deductible, the Plan would pay 90% of the covered health care costs for the family, assuming care is received from AHP providers.

The deductible for services sought within the Aetna or Excellus National Network would work in the same manner; however, the deductible, coinsurance and out-of-pocket maximum figures would differ. **Please note that if you receive a combination of services from AHP providers and providers within the Aetna or Excellus National Networks, your out-of-pocket costs will cross apply and count towards the deductibles and out-of-pocket maximums for the AHP providers tier and the Aetna or Excellus National Networks tier.**

**Coinsurance**
The percentage of the health care costs that the Plan pays for certain covered expenses once you have met your deductible. For example, if you reach the coinsurance phase and receive services from AHP providers, the Plan will pay 90% of your covered expenses; you will be responsible for the remaining 10% of your health care costs.

**Out-of-Pocket Maximum**
The maximum amount you will have to pay out of pocket for covered health and pharmacy expenses each plan year. Once you meet your out-of-pocket maximum (a combination of your deductible, copays and coinsurance payments), the Plan pays 100% of your covered medical and pharmacy expenses for the remainder of the year. The out-of-pocket maximum amounts will differ for services received by AHP providers, providers within the Aetna/Excellus National Network and out-of-network providers. However, if you receive
services from a combination of AHP providers, providers within the Aetna/Excellus National Networks or out-of-network providers, your out-of-pocket costs will cross apply for both your deductibles and out-of-pocket maximums. If you have one or more covered dependents on your plan, a $6,850 individual embedded out-of-pocket maximum would apply for the Tier 2/Aetna/Excellus National Network. Tiers 1 and 3 do not include an embedded out-of-pocket maximum.

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Annual Deductible</th>
<th>Coinsurance</th>
<th>Out-of-Pocket Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered at 100%</td>
<td>Amount you pay before the plan begins to pay benefits</td>
<td>Percentage the Plan pays for certain covered services once the deductible has been satisfied</td>
<td>The most you will pay for covered services during the calendar year. If you meet the out-of-pocket maximum, the Plan will pay 100% of the costs for your covered services</td>
</tr>
</tbody>
</table>

The Plan Year runs from January 1 through December 31

**Similarities and Differences**

**How the Health Care Plans Are Alike**

Both Plans:

- Are PPOs (Preferred Provider Organizations). By enrolling in a PPO, you get 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 from Accountable Health Partners (AHP) (tier 1), providers within the Aetna/Excellus National Networks (tier 2) or out-of-network (tier 3), but you may pay more for services received within the Aetna/Excellus National Networks (tier 2) or out-of-network (tier 3).

- Have a broad choice of networks of doctors, hospitals and service providers offered by the Accountable Health Partners and each of the two TPAs’ (Aetna and Excellus) National Networks.

- A Primary Care Physician (PCP) is not required, 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% coverage within the AHP provider panel and Aetna/Excellus National Networks to encourage regular check-ups and wellness services.

- Require you to pay more if you choose a brand name drug when a generic exists. You will be charged a higher rate, even if your doctor prescribes a brand name drug unless the generic is medically inappropriate in accordance with the TPA's medical man-
agement guidelines, such as if it is ineffective, not available at retail locations or has dangerous side effects.

- Qualifies you for a discount through the URMC Employee Pharmacy.
- Provide similar discounts for a 90-day supply of prescription drugs that is filled at the URMC Employee Pharmacy and mail order program.
- Require you to purchase specialty drugs from either the URMC Employee Pharmacy (preferred specialty drug provider for the University Health Plans) or your TPA's specialty vendor.
- Certain Services received from non-AHP providers within the Tier 2/Aetna/Excellus National Network will be covered at the AHP cost-sharing level. When you use an Aetna/Excellus National Network provider, you will receive coverage as though you used an AHP provider. See the 2016 Health Program Guide for additional information and a list of services.

**How the Plans Differ**

The health care plans vary when it comes to what you pay for:

- The employee's share of the Health Care Plan premium (taken as a pre-tax payroll deduction.)
- Your deductibles (YOUR PPO Plan includes an embedded deductible and out-of-pocket maximum, YOUR HSA-Eligible Plan does not include an embedded deductible or out-of-pocket maximum except for tier 2), coinsurance, copays and out-of-pocket maximums when you receive care.
- Your deductible under the YOUR PPO Plan only applies to inpatient, outpatient, emergency room and urgent care services; whereas, the YOUR HSA-Eligible Plan deductible applies to all medical and pharmacy expenses.
- Prescription drug coverage: If you are enrolled in the YOUR HSA-Eligible Plan, you pay the full cost of prescription drugs until the applicable single/family deductible has been met—after satisfying the deductible, you pay the pharmacy benefit copay or coinsurance for the respective generic, preferred brand or non-preferred brand drug(s).

Additionally, the plans offer different tax-advantaged accounts—the YOUR HSA-Eligible Plan includes the option to contribute to a Health Savings Account (HSA) and a Limited Purpose Health Care Flexible Spending Account (FSA), while the YOUR PPO Plan allows you to contribute to a Health Care Flexible Spending Account (FSA).

If you enroll in the YOUR HSA-Eligible Plan but do not contribute to an HSA, you can 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.
Plan Details

The YOUR HSA-Eligible Plan

The YOUR HSA-Eligible Plan differs from the YOUR PPO Plan in that it has:

- Lower pre-tax, payroll deductions
- Higher deductible and out-of-pocket maximum
- No embedded individual deductibles or out-of-pocket maximums (except for the $6,850 individual embedded out-of-pocket maximum for Tier 2/Aetna/Excellus National Network)
- The option to contribute to a Health Savings Account (HSA), a tax-advantaged savings account for qualified health care expenses, available to eligible individuals

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<thead>
<tr>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
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<tbody>
<tr>
<td>Accountable Health Partners</td>
<td>Aetna/Excellus National Network</td>
<td>Out-of-Network</td>
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### Overall Coverage (Single)

YOUR HSA-Eligible Plan deductible applies to medical and pharmacy expenses.

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<tr>
<th></th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
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<tbody>
<tr>
<td>Deductible</td>
<td>$1,300</td>
<td>$1,800</td>
<td>$2,500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Plan pays 90%</td>
<td>Plan pays 80%</td>
<td>Plan pays 60%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (includes deductible, coinsurance and copays)</td>
<td></td>
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</tr>
<tr>
<td>Full-time employees earning less than $47,200/year</td>
<td>$2,500</td>
<td>$3,500</td>
<td>$4,750</td>
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<tr>
<td>Out-of-Pocket Maximum (includes deductible, coinsurance and copays)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time employees earning more than $47,200/year and all part-time employees</td>
<td>$3,000</td>
<td>$4,000</td>
<td>$4,750</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexible Spending Account and/or Health Savings Account</td>
<td>Health Savings Account maximum: $3,350</td>
<td>Health Care Flexible Savings Account and Limited Flexible Savings Account Maximum: $2,550¹</td>
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1. The Tier 2 Aetna/Excellus National Network out-of-pocket maximum includes an individual embedded out-of-pocket maximum; see the 2016 Health Program Guide for additional information.
<table>
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<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td><strong>Overall Coverage (Employee and Spouse or Domestic Partner, Employee and Child(ren) or Family Coverage)</strong></td>
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<td><strong>Full-time employees earning less than $47,200/year</strong></td>
<td><strong>Full-time employees earning more than $47,200/year and all part-time employees</strong></td>
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<tr>
<td></td>
<td>$5,000</td>
<td>$7,500$^1</td>
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<tr>
<td><strong>Out-of-Pocket Maximum</strong> (includes deductible, coinsurance and copays)</td>
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<td></td>
<td>$6,000</td>
<td>$8,500$^1</td>
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<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
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<tr>
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<tr>
<td></td>
<td>Health Care Flexible Savings Account and Limited Flexible Savings Account Maximum: $2,550$^2</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong>$^3**</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Retail, Generic</strong> (up to 30 days’ supply)$^3$</td>
<td>$10 copay after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Retail, Preferred Brand</strong> (up to 30 days’ supply)$^3$</td>
<td>You pay 20% coinsurance ($25 min, $50 max) after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Retail, Non-Preferred Brand</strong> (up to 30 days’ supply)$^2$</td>
<td>You pay 35% coinsurance ($45 min, $90 max) after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Mail Order</strong> (up to 90 days’ supply)$^3$</td>
<td>2.5 times 30-day retail after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Prescription Diabetic Supplies and Equipment (pharmacy purchase)$^3$</strong></td>
<td>You pay 10% after deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

1. Tier 2/Aetna/Excellus National Network out-of-pocket maximum includes an individual embedded out-of-pocket maximum; see the 2016 Health Program Guide for additional information.

2. Under the YOUR HSA-Eligible Plan, you have the option to contribute to an HSA and a Limited Purpose FSA or a Health Care FSA.

3. If you are prescribed a brand name drug when a generic equivalent exists, you will be charged a higher rate, even if your doctor prescribes a brand name drug unless the generic is medically inappropriate in accordance with the TPA’s medical management guidelines, such as if it is ineffective, not available at retail locations or has dangerous side effects. 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 a designated specialty pharmacy. Some preventive drugs are considered preventive care and are covered at 100%; see the 2016 Health Program Guide for additional information.

4. 90-day supplies of maintenance drugs filled at the URMC Employee Pharmacy are eligible for a discount as well.
**Tax-Advantaged Account Options**

**What Is a Health Savings Account?**

A Health Savings Account (HSA) is a tax-advantaged savings account available to eligible individuals enrolled in a High Deductible Health Plan as defined by the IRS (i.e., the YOUR HSA-Eligible Plan). An HSA allows you to save tax-free dollars to pay for out-of-pocket qualified medical expenses (as defined by the IRS) incurred by you or your eligible dependents once your account is opened.

An HSA, like most bank accounts, is owned by the accountholder; therefore, you are responsible for meeting eligibility requirements pertaining to participation, contributions, disbursements and year-end tax filing requirements.

HSAs Offer a Triple Tax Advantage:

- Pre-tax or tax deductible contributions
- Tax-free interest and investment earnings
- Tax-free distributions, when used for qualified expenses

**University Funded HSA**

The University has decided to provide one-time employer funding to a Health Savings Account for eligible employees enrolled in the YOUR HSA-Eligible Plan during the 2016 Open Enrollment period. Throughout 2016, if enrolling in the YOUR HSA-Eligible Plan and attesting to their eligibility to have an HSA, newly hired, rehired, and newly benefit-eligible employees will be eligible for a prorated amount of the University-funded HSA. During the election period, if you attest to your eligibility to have an HSA (see the eligibility requirements on page 5 of the Tax-Advantaged Accounts Guide), the University will provide $200 towards an HSA for an employee enrolled in single coverage or $400 towards an HSA for an employee enrolled in coverage with one or more covered dependents. If you receive the employer funding and choose to contribute additional funds to your HSA, the total contribution amount for 2016 (employer funding + your contributions) cannot exceed the IRS annual contribution maximum for 2016 ($3,350 for single coverage, $6,750 if covering one or more dependents). See the 2016 Health Program Guide for additional information.

**What Is a Limited Purpose Health Care Flexible Spending Account?**

If you enroll in the YOUR HSA-Eligible Plan and elect a Health Savings Account, you are able to contribute to a Limited Purpose Health Care FSA. This type of FSA can provide reimbursement for qualified dental or vision expenses, but cannot reimburse any out-of-pocket health care expenses until the plan deductible has been satisfied, otherwise, the Limited Purpose FSA works like a Health Care FSA. The IRS maximum election for a Limited Purpose Health Care FSA is $2,550.
What Is a Health Care Flexible Spending Account

A Health Care Flexible Spending Account (FSA) is a tax-advantaged savings account that allows you to set aside money for qualified expenses incurred by you or your eligible dependents on a pre-tax basis. With a Health Care FSA, you have access to your full election on the effective date of your FSA and can reimburse yourself for qualified out-of-pocket medical, dental, prescription or vision services such as deductibles, copays and coinsurance with pre-tax funds.

You can elect a Health Care FSA if you:

- Are enrolled in the YOUR HSA-Eligible Plan and do not elect an HSA, or
- Are enrolled in the YOUR PPO Plan or
- Waive coverage through the University

For additional information, see the Tax-Advantaged Accounts Booklet and the 2016 Health Program Guide.

Flexible Spending Account Carryover Option

Traditionally, the IRS regulations have included a “use it or lose it” rule; FSA contributions can only be used to reimburse expenses incurred during the current Plan Year (January 1st–December 31st). However, the IRS regulators have issued guidance modifying the “use-it-or-lose-it” rule for health care flexible spending accounts (FSA) to allow employers the option to let participants carry over up to $500 of their unused balances from one plan year to the next. Faculty and staff members with a 2015 Health Care FSA or a Limited Purpose FSA will be able to carry over up to $500 of unreimbursed 2015 FSA dollars to the 2016 Plan Year. (You will still be able to submit reimbursement claims for health, dental, or vision expenses incurred during the 2015 Plan Year up to April 30, 2016.)

The following rules will apply to carryovers under the Health Care FSA:

- No more than $500 of your unused Health Care FSA amount for a Plan Year may be carried over for use in the next Plan Year.
- Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit and will not count toward the maximum dollar limit on annual salary reductions under the Health Care FSA.
• Eligible medical expenses incurred in the current Plan Year will be reimbursed first from your unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay your preceding Plan Year expenses during the run-out period, cannot exceed $500, and will count against the $500 maximum carryover amount.

• If you enroll for a Health Care FSA for the new Plan Year, your funds will carry over to the same type of FSA you have elected for your new contributions.

• If you are otherwise eligible for the Health Care FSA for a Plan Year, but you do not make a Health Care FSA election, you may still use any carryovers from the preceding Plan Year for current or preceding Plan Year eligible medical expenses (in accordance with Plan terms).
  • If you waive University health care plan coverage, your Health Care FSA funds will remain in the same type of FSA (the general Health Care FSA or the Limited Purpose FSA) that you had the prior Plan Year.
  • If you enroll for University health care plan coverage, your Health Care FSA funds will carry over to the general Health Care FSA if you are enrolled in the YOUR PPO Plan option, and to the Limited Purpose FSA if you are enrolled in the YOUR HSA-Eligible Plan option.

**Note:** Under IRS rules, if you carry over any unused general Health Care FSA amounts to a general Health Care FSA for the next Plan Year, you (and any other individual whose expenses can be reimbursed by your Health Care FSA) cannot contribute to an HSA during the entire next Plan Year. Therefore, if you are not making a new FSA election and you are also waiving University health care plan coverage for the new Plan Year, but you (or someone else whose expenses can be reimbursed by your Health Care FSA) would like to contribute to an HSA during the next Plan Year, then you must either waive (decline) a general Health Care FSA carryover before that Plan Year begins or request that your remaining general Health Care FSA funds be rolled over to the Limited Purpose FSA, using a form available from the Benefits Office. If you waive the carryover, you may continue to submit claims for expenses incurred during the current Plan Year until the end of the run-out period (April 30th of the following Plan Year), to be reimbursed from your available general Health Care FSA amounts. If those claims do not use up your entire general Health Care FSA balance for the current Plan Year, any unused amounts will be forfeited in accordance with your waiver.

• You must be a participant in the Health Care FSA as of the last day of the Plan Year to benefit from the carryover. Termination of employment and cessation of eligibility will generally result in a loss of carryover eligibility unless a COBRA election is made.

For additional information, see the Tax-Advantaged Account booklet and the 2016 Health Program Guide.
Notice of Medical Plan Grandfather Status under the Patient Protection and Affordable Care Act

The University of Rochester believes that the FSA and EAP (including Lifestyle Management) Plans are “grandfathered health plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act or health care reform). As permitted by this law, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to University of Rochester, the Plan Administrator at 1-585-275-2084. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Useful Resources

All resources are available on the Benefits website at www.rochester.edu/benefits and in the Benefits Office.

- **2016 YOUR PPO Plan Booklet and YOUR HSA-Eligible Plan Booklet**: Brief overview of the coverage options available to eligible University faculty and staff members.

- **Tax Advantaged Accounts Booklet**: Useful information regarding Health Savings Accounts and Flexible Spending Accounts.

- **2016 Health Plans Comparison Chart**: Comparison chart detailing the coverage differences between the YOUR PPO Plan and the YOUR HSA-Eligible Plan.

- **2016 Health Program Guide**: Detailed information regarding the University’s comprehensive Health Program that is available to eligible University Faculty and Staff members and their covered dependents.

- **ALEX**: Online benefits decision tool designed to assist employees in understanding various benefit options and provide assistance in making educated benefit related decisions. Available on the Benefits Video page at https://www.rochester.edu/working/hr/benefits/video/.

- **YOUR PPO Plan, YOUR HSA-Eligible Plan, Flexible Spending Accounts, and the Health Savings Account videos**: Short videos designed to provide a brief overview of the University Health Care Plans and the tax-advantaged accounts available to eligible employees.
Appendix A

University of Rochester Health Care Program’s Definition of Benefit Eligible Dependents

Dependents Eligible for Benefits under the University of Rochester’s Health Care Plans, Prescription Drug Plan, Dental Plans, and pre-tax premiums under the Cafeteria Plan include:

- Your current spouse.
- Your domestic partner (same-sex or opposite-sex).*
- Your children and/or your domestic partner’s children* up to the end of the month they turn age 26, regardless of access to other health care coverage through their own or a spouse’s employment, marital status or student status.
- Your children who are handicapped prior to age 26 and are dependent on you for support.

Your children include:

- Biological children,
- Legally adopted children,
- Stepchildren,
- Children who are placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction, and
- Domestic Partner’s Children*.

* Domestic Partners (Same-Sex or Opposite-Sex) and children of domestic partners are eligible for coverage under the University’s Health Program provided that the employee and his/her domestic partner satisfy all of the criteria in the Certification of Domestic Partners Status Form. See the 2016 Health Program Guide for additional information.

Please Note: If you will be adding a handicapped child age 26 or older or a domestic partner and child(ren) to your health and/or dental coverage, you will need to complete the respective Handicapped Dependent Form or Certification of Domestic Partners Status Form for these dependents. These forms are available online at www.rochester.edu/benefits and at the Benefits Office. Please return the completed form at the same time you are submitting your Benefit Program Enrollment/Change Form to HR Administrative Services, 910 Genesee Street, Suite 100, PO Box 278955, Rochester, NY 14627.