The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-499-1275 or 1-315-470-7111. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at You can view the Glossary at www.cciio.cms.gov or https://www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Domestic Network Provider: None; Participating Provider: $500; Non-Participating Provider: $500	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Medical**: Domestic Network Provider: $2,000; Participating Provider: $3,000; Non-Participating Provider: $4,000. **Prescription drugs**: $6,000 Individual/ $11,700 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Cost-sharing for non-essential specialty drugs if you fail to confirm enrollment in the SaveonSP program, third party financial assistance, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You pay the least if you use a provider in the Crouse Network. You pay more if you use a network provider. You will pay the most if you use an non-participating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an non-participating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Domestic Network Provider (You will pay the least)	Participating Provider (You will pay more)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	$45 copay/visit Deductible does not apply	30% coinsurance	None
	Specialist visit	$20 copay/visit	$45 copay/visit Deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	Adult Physical: No charge; Adult Immunizations: No charge; Well Child Visit: No charge	Adult Physical: No charge; Adult Immunizations: No charge; Well Child Visit: No charge Deductible does not apply	Adult Physical: 30% coinsurance; Adult Immunizations: 30% coinsurance; Well Child Visit: 30% coinsurance	Adult annual physical: One (1) exam per year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No charge Blood work: No charge	X-ray: 20% coinsurance Blood work: 20% coinsurance	X-ray: 30% coinsurance Blood work: 30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	1-30 day supply: $4 copay; 31-60 day supply: $4 copay up to $8 copay; 61-100 day supply: $4 copay up to $12 copay	40% coinsurance/ prescription (retail & mail order) Deductible does not apply	Not covered	Domestic: covers up to a 100 day supply (retail prescription only) Participating pharmacy: Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription).

* For more information about limitations and exceptions, see your Employer for a copy of the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Domestic Network Provider (You will pay the least)	Participating Provider (You will pay more)	Non-Participating Provider (You will pay the most)	
More information about **prescription drug coverage** is available at www.excellusbcbs.com	Brand name drugs (Tier 2)	1-30 day supply: $4 copay up to $30 copay; 31-60 day supply: $4 copay up to $60 copay; 61-100 day supply: $4 copay up to $90 copay (retail)	40% coinsurance/ prescription (retail & mail order) Deductible does not apply	Not covered	Certain prescription drugs require preauthorization. If you don't get preauthorization, your prescription drug will not be covered. **SAVEONSP PROGRAM:** For certain specialty drugs, you must confirm enrollment in SaveOnSP by calling 1-800-683-1074. Specialty drugs available through the SaveOnSP program are considered non-essential; therefore, if you fail to participate and/or provide consent to SaveonSP to monitor your pharmacy account, any coinsurance you pay for specialty drugs available through SaveOnSP will not count toward your out-of-pocket limit. Accelerated Approved Drugs are not covered if included on the Accelerated Approved Drug exclusion list available at www.excellusbcbs.com.
	Non-brand name drugs (Tier 3)	1-30 day supply: $4 copay up to $70 copay; 31-60 day supply: $4 copay up to $140 copay; 61-100 day supply: $4 copay up to $210 copay (retail)	40% coinsurance/ prescription (retail & mail order) Deductible does not apply	Not covered	
	Specialty drugs (Tier 4)	40% coinsurance up to a maximum $100 copay (retail)	40% coinsurance/ prescription (retail & mail order) Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	$500 copay/visit Deductible does not apply	30% coinsurance	None
	Physician/surgeon fees	No charge	No charge Deductible does not apply	No charge	None
If you need immediate medical attention	Emergency room care	No charge	$100 copay/visit Deductible does not apply	$100 copay/visit Deductible does not apply	None
	Emergency medical transportation	Not covered	$100 copay/visit Deductible does not apply	$100 copay/visit Deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Domestic Network Provider (You will pay the least)	Participating Provider (You will pay more)	Non-Participating Provider (You will pay the most)	
	Urgent care	No charge	$70 copay/visit Deductible does not apply	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	$2,000 copay/visit Deductible does not apply	$2,000 copay/visit, then 30% coinsurance	None
	Physician/surgeon fees	No charge	No charge Deductible does not apply	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	$25 copay/visit Deductible does not apply	30% coinsurance	None
	Inpatient services	No charge	$2,000 copay/visit Deductible does not apply	$2,000 copay/visit, then 30% coinsurance	
If you are pregnant	Office visits	No charge	No charge Deductible does not apply	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.
	Childbirth/delivery professional services	No charge	No charge Deductible does not apply	30% coinsurance	
	Childbirth/delivery facility services	No charge	$2,000 copay/visit Deductible does not apply	$2,000 copay/visit, then 30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	No charge Deductible does not apply	30% coinsurance	40 visits/year
	Rehabilitation services	No charge	20% coinsurance	30% coinsurance	45 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	No charge	20% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Domestic Network Provider (You will pay the least)	Participating Provider (You will pay more)	Non-Participating Provider (You will pay the most)	
	Skilled nursing care	No charge	No charge Deductible does not apply	30% coinsurance	120 days/year
	Durable medical equipment	No charge	No charge Deductible does not apply	30% coinsurance	None
	Hospice services	No charge	No charge Deductible does not apply	30% coinsurance	Family bereavement counseling limited to five (5) visits per year
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Emergency medical transportation (Domestic Network Provider)
- Long-term care
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Reproductive services

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

* For more information about limitations and exceptions, see your Employer for a copy of the plan or policy document.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. Additionally, a consumer assistance program can help you file your appeal. Contact Community Service Society of New York, Community Health Advocates, 633 Third Avenue, 10th floor, New York, NY 10017, (888) 614-5400, http://www.communityhealthadvocates.org/ (website), cha@cssny.org (email). A list of states with Consumer Assistance Programs is available at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of domestic network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other copayment	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

Managing Joe's Type 2 Diabetes
(a year of routine domestic network care of a well- controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other copayment	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$200**

Mia's Simple Fracture
(domestic network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other copayment	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$940
The total Mia would pay is	**$960**

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