




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](http://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:
<b>What is the overall <a href="#">deductible</a>?</b>	Domestic Network Provider: None; <a href="#">Participating Provider</a> : \$200 Individual/ \$500 Family; <a href="#">Non-Participating Provider</a> : \$200 Individual/ \$500 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>Medical:</b> Domestic Network Provider: \$1,000 Individual/ \$3,000 Family; <a href="#">Participating Provider</a> : \$1,000 Individual/ \$3,000 Family; <a href="#">Non-Participating Provider</a> : \$1,000 Individual/ \$3,000 Family. <b>Prescription drugs:</b> \$6,000 Individual/ \$11,700 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Cost-sharing</a> for non-essential <a href="#">specialty drugs</a> if you fail to confirm enrollment in the SaveonSP program, third party financial assistance, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.excellusbcb.com">www.excellusbcb.com</a> or call 1-800-499-1275 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You pay the least if you use a <a href="#">provider</a> in the Crouse Network. You pay more if you use a <a href="#">network provider</a> . You will pay the most if you use an <a href="#">non-participating provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">non-participating provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a referral.

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	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 <a href="#">Deductible</a> does not apply	Adult Physical: 30% <a href="#">coinsurance</a> ; Adult Immunizations: 30% <a href="#">coinsurance</a> ; Well Child Visit: No charge	Adult annual physical: One (1) exam per year.  You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: No charge Blood work: No charge	X-ray: 20% <a href="#">coinsurance</a> Blood work: 20% <a href="#">coinsurance</a>	X-ray: 20% <a href="#">coinsurance</a> Blood work: 20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at	Generic drugs (Tier 1)	1-30 day supply: \$4 <a href="#">copay</a> ; 31-60 day supply: \$4 <a href="#">copay</a> up to \$8 <a href="#">copay</a> ; 61-100 day supply: \$4 <a href="#">copay</a> up to \$12 <a href="#">copay</a>	40% <a href="#">coinsurance</a> /prescription (retail & mail order) <a href="#">Deductible</a> 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)	
<a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a>	Brand name drugs (Tier 2)	1-30 day supply: \$4 <a href="#">copay</a> up to \$30 <a href="#">copay</a> ; 31-60 day supply: \$4 <a href="#">copay</a> up to \$60 <a href="#">copay</a> ; 61-100 day supply: \$4 <a href="#">copay</a> up to \$90 <a href="#">copay</a> (retail)	40% <a href="#">coinsurance</a> /prescription (retail & mail order) <a href="#">Deductible</a> does not apply	Not covered	<p>Certain <a href="#">prescription drugs</a> require <a href="#">preauthorization</a>. If you don't get <a href="#">preauthorization</a>, your <a href="#">prescription drug</a> will not be covered.</p> <p><b>SAVEONSP PROGRAM:</b> For certain <a href="#">specialty drugs</a>, you must confirm enrollment in SaveOnSP by calling 1-800-683-1074. <a href="#">Specialty drugs</a> available through the SaveOnSP program are considered non-essential; therefore, if you fail to participate and/or provide consent to SaveonSP to monitor your pharmacy account, any <a href="#">coinsurance</a> you pay for <a href="#">specialty drugs</a> available through SaveOnSP will not count toward your <a href="#">out-of-pocket limit</a>.</p> <p>Accelerated Approved Drugs are not covered if included on the Accelerated Approved Drug exclusion list available at <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a>.</p>
	Non-brand name drugs (Tier 3)	1-30 day supply: \$4 <a href="#">copay</a> up to \$70 <a href="#">copay</a> ; 31-60 day supply: \$4 <a href="#">copay</a> up to \$140 <a href="#">copay</a> ; 61-100 day supply: \$4 <a href="#">copay</a> up to \$210 <a href="#">copay</a> (retail)	40% <a href="#">coinsurance</a> /prescription (retail & mail order) <a href="#">Deductible</a> does not apply	Not covered	
	<a href="#">Specialty drugs</a> (Tier 4)	40% <a href="#">coinsurance</a> up to a maximum \$100 <a href="#">copay</a> (retail)	40% <a href="#">coinsurance</a> /prescription (retail & mail order) <a href="#">Deductible</a> does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	No charge	No charge <a href="#">Deductible</a> does not apply	No charge	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	Not covered	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	

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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)	
	<a href="#">Urgent care</a>	No charge	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	25% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	25% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	None
	Physician/surgeon fees	No charge	No charge <a href="#">Deductible</a> does not apply	No charge	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	25% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
	Inpatient services	No charge	25% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	25% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	
If you are pregnant	Office visits	No charge	No charge <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> 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 <a href="#">Deductible</a> does not apply	No charge <a href="#">Deductible</a> does not apply	
	Childbirth/delivery facility services	No charge	25% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	25% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	No charge <a href="#">Deductible</a> does not apply	No charge	40 visits/year
	<a href="#">Rehabilitation services</a>	No charge	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	45 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	No charge	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	No charge	No charge <a href="#">Deductible</a> does	20% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not	120 day limit

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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)	
			not apply	apply	
	<a href="#">Durable medical equipment</a>	No charge	No charge <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	No charge	No charge	No charge	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](#).)

- Acupuncture
- 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.)

- 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](http://www.HealthCare.gov) or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or <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](mailto:cha@cssny.org) (email). A list of states with Consumer Assistance

\* For more information about limitations and exceptions, see your Employer for a copy of the [plan](#) or policy document.

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 coinsurance](#) 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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$70</b>

### 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 coinsurance](#) 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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$160
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$240</b>

### Mia's Simple Fracture

(domestic network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$940
<b>The total Mia would pay is</b>	<b>\$970</b>

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