Benefits Summary

Physician

Jan 2025

Crouse Hospital's total compensation package combines a competitive salary with one of the most comprehensive health and benefits packages in Central New York. We take pride in offering you the best and most affordable options.

Paid Time Off

HOLIDAYS

- Eligible full-time employees are entitled to 6 paid holidays beginning 1st of the month following date of hire.
    - New Year's Day
    - Memorial Day
    - Independence Day
    - Labor Day
    - Thanksgiving
    - Christmas

BEREAVEMENT LEAVE

Full time and part time employees may receive up to 3 consecutive paid days for the death of an immediate family member. Immediate family includes mother, father, foster parent, step parent, spouse, child, sister, brother, mother and father in-laws, daughter and son in-laws, grandparent, great grandparent and parents and children of one's domestic partner. Divorced in-law relationships are not applicable.

An additional 2 days may be taken with pay in the event of the death of an employee's spouse, domestic partner or child.

In addition the Hospital will grant requests for up to 2 days of paid or unpaid time for bereavement leave for the following family members – mother, father, foster parent, step parent, sister, brother, mother and father in-laws, grandparent, great grandparent and parent and child of one's domestic partner. Divorced in-law relationships are not applicable.

JURY DUTY

Upon completion of their probationary period, full-time employees will be paid the difference between the jury duty fee and their straight time hourly rate or regular salary when serving as a juror during their scheduled work hours.

Part-time employees will be paid a pro-rated amount based on their vouchered status and straight time hourly rate when serving as a juror during their scheduled work hours.

Certain employees may be excused from work but still be compensated when serving as jurors outside of their scheduled work hours (*e.g.*, when an employee is working on a night shift schedule and serves as a juror earlier that same day).

MILITARY LEAVE

- Full-time employees who are in the National Guard or Reserves are paid the difference between their base rate wages and their military pay for mandatory annual military reserve training duty to a maximum of 2 weeks.

Health Benefits

MEDICAL/VISION/DENTAL INSURANCE

- Benefits are available to new employees on the 1st of the month following date of hire.
- Benefit selections must be made within 7 days from date of hire.
- Employees can add or modify benefit elections during the annual open enrollment period.
- All benefit enrollments are for 1 calendar year (except dental which is a 2 year enrollment).
- Employee contributions are deducted pre-tax through payroll deduction.

MEDICAL AND DENTAL OPT-OUT BENEFIT

- Employees may opt-out of our medical and dental plans and receive $23.00 credit per paycheck for medical and $5.00 credit per paycheck for dental.
- Employees who have other coverage (through a spouse or another employer) can receive this credit as long as they provide proof that they have coverage elsewhere.

ALLOWABLE BENEFIT CHANGES

- Employees are allowed to make certain benefit changes as a result of experiencing a life status change.
- Notification of a qualifying event must be made to Human Resources within 30 days of experiencing the event. Proof of qualifying event will be required.
- The following are qualifying events that allow benefit changes outside of the annual open enrollment period:
    - Marriage
    - Separation
    - Birth/Adoption
    - Divorce
    - Death
    - Spouse/Dependent loss of coverage

HOSPITAL DISCOUNT

- Employees receive a 25% discount on their gross bill for inpatient and outpatient services performed at Crouse Hospital.
- These services may include procedures such as elective surgeries or services not covered by insurance plans, fees incurred prior to health insurance eligibility and/or fees incurred by those not covered under the Hospital's insurance plans.
- This discount is applied toward out-of-pocket costs after the employee's insurance company has paid its portion of the bill. This discount extends to services provided for employees and dependents residing in the same household.

Life Insurance

LIFE & ACCIDENTIAL DEATH & DISMEMBERMENT (AD&D)

- Full-time and part-time employees (working 20 or more hours per week) receive no cost life insurance and AD & D benefits equal to 1.5 times their annual salary up to a maximum of $100,000.
- Part-time employees (working less than 20 hours per week) receive a benefit of $3,500.
- The life insurance benefit is reduced to 67% at age 70 and 50% at age 75. The part-time benefit is $3500 with no reduction schedule.
- Employees may also purchase additional protection for themselves for up to 3 times their basic annual earnings to a maximum of $250,000 without evidence of insurability or up to $500,000 with evidence of insurability.
- Employees may also purchase additional protection for their spouse at 50% of the employee's option amount up to $25,000 without evidence of insurability or $150,000 with evidence of insurability. Employees may also purchase up to $10,000 for each dependent child.

Disability

SHORT TERM DISABILITY

- All full-time and part-time employees working 20 or more hours per week will be provided at no cost short term disability coverage for non-work related illness or injuries.
- The benefit pays 40% of the employee's base weekly earning to a maximum of $1,000 after a 14 day waiting period. The benefit is payable to a maximum of 26 weeks.

Flexible Spending Accounts

HEALTH CARE REIMBURSEMENT ACCOUNT

- Employees may elect to contribute up to $3,300 in the 2025 calendar year to a pre-tax Health Care Reimbursement Account to be used for additional medical, dental, and vision expenses. These expenses may include items not covered by your medical/dental/vision insurance such as:
    - Deductibles, co-insurance amounts, excess over reasonable and customary charges and excess over scheduled or annual maximums.
    - Vision expenses including exams, prescription eyeglasses, contact lenses and visual impairment services.
    - Hearing expenses including exams, hearing aids and hearing impairment services.
    - Mental health or substance abuse treatment provided by a licensed practitioner.
    - The Internal Revenue Service Publication 502 lists all eligible expenses; for a complete listing please refer to www.irs.gov.

  Claims for expenses that are incurred during any calendar year can be submitted until March 31st of the following year.
- Employees may pay for eligible expenses by using an electronic debit card.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

- Employees may elect to contribute up to $5,000 each calendar year to a pre-tax Dependent Care Reimbursement Account.
- The Dependent Care Reimbursement Account can only provide reimbursement so that employees (and their spouses, if applicable) can work, look for work, or attend school full-time. It may also reimburse for dependent care expenses incurred if the employee's spouse is disabled.
- Claims for expenses that are incurred during any calendar year can be submitted until March 31st of the following year.
    - Eligible dependents include:
        - Dependent children under the age of 12 who are claimed as a personal exemptions for tax purposes
        - A disabled spouse or another disabled dependent
        - Elderly parents who are physically or mentally unable to care for themselves.
- Expenses that can be reimbursed through a Dependent Care Reimbursement Account are the same as those eligible for income tax credits. Qualified expenses cannot be applied to both the reimbursement account and tax credits.
    - Examples of eligible expenses include payments to:
        - Day Care Centers
        - Nursery Schools
        - Registered Day Care Providers
        - Live-in help whose primary function is dependent care
        - Elder care providers
- Payments to the employee's own child age 19 or younger or to any other dependent the employee can claim for tax purposes are not eligible expenses.

Retirement Benefits

401(k) BENEFITS

A 401(k) plan is a government approved tax-favored, savings and retirement program that permits you to save part of your salary on a pre-tax basis. The plan allows you to reduce your taxes while saving for your future.

- New employees will have 4% of their pay automatically withheld from their paychecks and will have 30 days from the date of hire to either cancel or increase their contribution amount.

- The plan includes a matching feature from the Hospital as well as an annual profit sharing contribution for employees that work at least 1,000 hours in a calendar year.

    - Employer match is 25% up to the first 6% of your salary you defer.
    - The profit sharing contribution is as follows:
        - 1-5 Years of Service = 1% of pay
        - 6-10 Years of Service = 2% of pay
        - 11-20 Years of Service = 3% of pay
        - 20+ Years of Service = 4% of pay

- The 401k has a vesting schedule related to the Hospital's contributions. You are always 100% vested with your contributions.
    - Employer Contribution Vesting Schedule:
        - 1 Year of Service = 25% vested
        - 2 Years of Service = 50% vested
        - 3 Years of Service = 75% vested
        - 4 Years of Service = 100% vested

- Employees may increase or decrease the amount of their salary reduction anytime by registering and logging on to the VOYA website at www.voyaretiremenplans.com.

Work/Life Benefits

EMPLOYEE HEALTH & WELLNESS SERVICES

- *Simply Well* is Crouse Hospital's Wellness Program dedicated to helping our employees live a happy and healthy lifestyle. A variety of programs and events are offered to make our employee's journey to personal health and well-being successful. Some of our programs include:
    - On-site Weight Watchers Meetings
    - Discounts on gym memberships
    - On-site Yoga, Pilates, and other fitness classes
    - Wellness challenges
    - Smoking cessation
    - Disease Management and Nurse coaching telephone support
    - Free online wellness assessment
    - Lunch & Learn sessions on a variety of wellness topics

  For more information about Simply Well, visit our wellness website at crouse.org/simplywell or by email at simplywell@crouse.org.

- The Employee Health Office is located on 8th floor of the Memorial Building. Hours of operation are 6:30 am - 3:30 pm, Monday through Friday. The office provides quality care for employees, as well as promoting our Simply Well program, and occupational health and safety. They can be contacted by phone at 315-470-7424. Some of their services include:
    - Pre-employment screenings
    - Annual health assessments
    - Annual immunization and flu shot updates
    - Health counseling and sick visits
    - Workers Compensation and injury reporting

EMPLOYEE PHARMACY

- The Employee Pharmacy is located in the basement level of the hospital. Hours of operation are 7 am - 4:00 pm Monday through Friday and can be contacted at 315-470-7520. They provide the convenience of an onsite pharmacy dedicated to all employees of the hospital. Some of their services include:
    - Prescription medications
    - "At-cost" pricing for over-the-counter medications and supplies
    - Payroll deduction and use of flex spending debit cards are accepted
- Employees who do not participate in the hospital's medical coverage may purchase prescriptions at the employee pharmacy at hospital cost.

HELP PEOPLE EMPLOYEE ASSISTANCE PROGRAM (EAP)

- HelpPeople, the hospital's employee assistance program, is housed in various locations. They provide free, confidential assistance and counseling for a wide range of personal problems for all employees and their immediate families. Some of their services include:
    - Stress coping
    - Communication tools
    - Bereavement counseling
    - Financial stress counseling
- Crouse Hospital shuttle service is available to the Syracuse location during regular work hours
- A 24 hour hotline is available 315-470-7447 or 1-800-777-6110.

COMMUNITY EDUCATION CLASSES

- Employees are eligible for a discount on community education classes that are held at the Marley Education Center. These classes include the First Steps Maternity & Family Education classes. CPR training (BLS, ACLS, PALS, etc.) is also available onsite to all employees for free.

CREDIT UNION

- Crouse Hospital Federal Credit Union is located in the Crouse Business Center at 730 South Crouse Ave in Syracuse. They provide standard banking services, great loan rates, holiday clubs, discount movie and theme park tickets and a variety of group bus trips.

DIRECT DEPOSIT

- Direct deposit is available for any bank and/or credit union.
- Direct deposit can be split into more than one bank account.
- Direct deposit can also be made to a Visa Payroll Debit Card issued by Crouse Hospital. The card can be used at ATM's, retail stores, gas stations, grocery stores worldwide, and wherever Visa debit cards are accepted.

CLOCKTOWER CAFE

- Employees receive a discount on all items
- Payroll deduction is available for purchases made in the cafeteria
- Employees working on Thanksgiving or Christmas receive a free meal during their shift

CORPORATE DISCOUNTS

- Group discounts are available on cell phones, wireless plans, wholesale club memberships, office supplies, car rentals and more.

PAY PERIOD

- Employees are paid every other Monday.
- The amount paid includes all hours worked during the two weeks prior to the preceding week, beginning on a Sunday and ending on a Saturday.

Excellus

Excellus BluePPO

Custom Rx

Benefit Time Period: 01/01/2025 - 12/31/2025

CROUSE HOSPITAL - Choice Plan

General Information

Cost Sharing Expenses

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$250	$250	
Deductible - Plus 1/Family	$0	$750	$750	Each individual does not exceed the single deductible.
Coinsurance	0%	20%	30%	Co-insurance is calculated on the allowed amount.
Annual Out of Pocket Maximum - Single	$1,000	$2,000	$3,000	Out-of-pocket maximums include deductible, coinsurance and Medical copays. Domestic and INN aggregate together. RX Out of Pocket Maximum: $6,000 individual/ $11,700 family not combined with medical Out-of-Pocket Maximum.
Annual Out of Pocket Maximum - Plus 1	$2,000	$3,000	$4,000	Out-of-pocket maximums include deductible, coinsurance and Medical copays. Domestic and INN aggregate together. RX Out of Pocket Maximum: $6,000 individual/ $11,700 family not combined with medical Out-of-Pocket Maximum.
Annual Out of Pocket Maximum - Family	$3,000	$4,000	$6,000	Same as above for Plus 1 plan

Office Visit Cost Shares

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$20 Copayment	$45 Copayment	30% Coinsurance Subject to Deductible	Co-insurance is calculated on the allowed amount
Cost Share - Specialist	$20 Copayment	$45 Copayment	30% Coinsurance Subject to Deductible	Co-insurance is calculated on the allowed amount

Plan Limits

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year				Calendar Year Benefits
Diabetic Preauthorization and Step Therapy				Yes

Who is Covered

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage				Not Covered

Inpatient Services

Inpatient Facility

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Covered in Full	$2,000 Copayment	$2,000 Copayment Subject to Deductible	INN/OON Copay DOES NOT apply to dependents under 19 yrs of age. Maximum 3 copays per yr. applies to INN only. OON 30% Coinsurance after copay and deductible.
Mental Health Care	Covered in Full	$2,000 Copayment	$2,000 Copayment Subject to Deductible	INN/OON Copay DOES NOT apply to dependents under 19 yrs of age. Maximum 3 copays per yr. applies to INN only. OON 30% Coinsurance after copay and deductible.
Substance Use Detoxification	Covered in Full	$2,000 Copayment	$2,000 Copayment Subject to Deductible	INN/OON Copay DOES NOT apply to dependents under 19 yrs of age. Maximum 3 copays per yr. applies to INN only. OON 30% Coinsurance after copay and deductible.
Skilled Nursing Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	120 Days per year Limits are combined INN and OON.
Physical Rehabilitation	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	120 Visits per year Limits are combined INN and OON.
Maternity Care	Covered in Full	$2,000 Copayment	$2,000 Copayment	INN/OON Copay DOES NOT apply to dependents under 19 yrs of age. Maximum 3 copays per yr. applies to INN only. OON 30% Coinsurance after copay and deductible.

Inpatient Professional Services

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	Covered in Full	$500 Copayment	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	Covered in Full	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	INN Deductible waived for Genetic Testing
Radiation Therapy	Covered in Full	20% Coinsurance	30% Coinsurance Subject to Deductible	
Chemotherapy	Covered in Full	20% Coinsurance	30% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Dialysis	Covered in Full	20% Coinsurance	30% Coinsurance Subject to Deductible	
Mental Health Care	$20 Copayment	$25 Copayment	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$20 Copayment	$25 Copayment	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	40 Visits per year Visits 41 - 365 Domestic - CIF, INN - 20% Coinsurance. OON: 30% Coinsurance, after deductible. Limits are combined INN and OON
Home Infusion Therapy	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	

Hospice Care

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	Professional interpretation charges Domestic/INN CIF, OON deductible and coins
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	Professional interpretation charges Domestic/INN CIF, OON deductible and coins INN: Deductible waived for Genetic Testing
Radiation Therapy	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $20 Copayment	PCP/Specialist - $25 Copayment	30% Coinsurance Subject to Deductible	HYPNOTHERAPY - Domestic / INN / OON 50% up to $50 , 4 visits/yr combined, does not apply to Ded or OOP. SMOKING CESSATION - Domestic / INN Covered in Full. Two attempts per year. No coverage OON.

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Maternity Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Initial Visit copay $15 Domestic $25 INN
Telehealth	PCP/Specialist - $20 Copayment	PCP/Specialist - $45 Copayment	30% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	
Chiropractic Care	PCP/Specialist - $20 Copayment	PCP/Specialist - $20 Copayment	50% Coinsurance	20 visits per year. OON - 50% up to $50 max per visit.
Allergy Testing	PCP/Specialist - $20 Copayment	PCP/Specialist - $45 Copayment	30% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	PCP/Specialist - $45 Copayment	30% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums). Serum Domestic/ INN CIF, OON deductible and coins
Hearing Evaluations Routine	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full	

Rehab and Habilitation

Outpatient Facility

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	Covered in Full	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical and occupational therapy.
Occupational Rehabilitation	Covered in Full	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year 45 Limit combined with Physical Rehabilitation
Speech Rehabilitation	Covered in Full	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Not combined with Physical or Occupational.

Outpatient Professional Services

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical and occupational therapy. Massage Therapy 50% to $35 - Domestic, IN and Out. 16 Visit combined Max
Occupational Rehabilitation	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year 45 Limit combined with Physical Rehabilitation.
Speech Rehabilitation	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Not combined with Physical or Occupational

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per calendar year
Adult Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Per AAP Guidelines
Routine GYN Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 per calendar year
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Initial Co-pay applies for Domestic and INN
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per year
Mammography Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Covered through the Rx Benefit if purchased through the Pharmacy
Treatment of Diabetes - Insulin	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Covered through the Rx Benefit if purchased through the Pharmacy
Diabetic Equipment	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Covered through the Rx Benefit if purchased through the Pharmacy
Durable Medical Equipment (DME)	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - 50% Coinsurance	PCP/Specialist - 50% Coinsurance	50% Coinsurance	16 Visits per year 50% up to $50 max per visit.
Private Duty Nursing	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	

Diagnoses

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	Covered in Full	$100 Copayment	$100 Copayment	Copay waived for Dependents under 19 Emergency. Domestic CIF for Emergency and Non-Emergency Services. INN $100 copay, OON $100 copay then 30%.

Transportation

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	Not Covered	$100 Copayment	$100 Copayment	Domestic Not Available

Urgent Care

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	Covered in Full	$70 Copayment	30% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	N/A	N/A	N/A	Routine Adult Eyewear is not covered. Eyewear is only covered if following Intraocular Surgery or Cataract Surgery: Limit Once Every 24 months. Domestic and INN CIF, OON Deductible/ Coinsurance

Rx Benefits

Rx Plan

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Rx Plan				Custom Rx

Rx Benefits

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	100	30		
Days Supply Per Mail Order	N/A	N/A		
Copays Per Mail Order Supply	N/A	N/A		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

Excellus

Dental Blue Options Summary of Benefits

Employer Group name: Crouse Hospital - Comprehensive

Plan Type: Contributory (employer-sponsored)
Product Type: Passive PPO (same coinsurance in & out-of-network)

Plan Features

Network: Reimbursement In network: Crouse Hospital FS Reimbursement Out-of-network: East 85% UCR Reimbursement Out of Area: National Dental Network GRID+ DenteMax Reimbursement Out of Area Out-of-network: East 85% UCR	Dependent / student age limit: 19/25
Annual Plan Deductible: $0 Ind / $0 Fam Deductible applies to: N/A	Annual Plan Maximum per member: $2,500 per member Annual Max applies to: Classes I, II, IIA III services
Ortho Age Limit: All members on contract Lifetime Orthodontia Maximum: $2,000 per member (does not apply toward annual plan maximum)	

Plan Benefits

Type of Care	Benefits Included	Excellus BCBS Pays: In-Network	Excellus BCBS Pays: Out-of-Network
Class I Preventive & Diagnostic	• Cleanings & exams - twice per calendar year • Fluoride treatments – twice per calendar year to age 16 • Sealants – unrestored 1st and 2nd permanent molars, once every 36 months • Bitewing x-rays – up to 4 every calendar year • Full mouth/Panoramic x-rays – once every 36 months • Diagnostic Photograph/Facial Images – once per calendar year • Space maintainers – up to age 16 • Emergency palliative treatment	100%	100%
Class II Basic Restorative	• Fillings – amalgam & composite; each surface covered once every 12 months • Oral surgery – simple extractions	80%	80%
Class IIA Basic Restorative	• Oral surgery – surgical extractions • Endodontics – root canal treatment • Periodontal surgery – osseous surgery, gingivectomy, gingival flap procedure – covered once per quadrant every 36 months • Periodontal scaling & root planing – once per quadrant every 24 months	80%	80%

This is not a contract or binding agreement; it is a summary of benefits and services. For complete details, please refer to your member contract.

Excellus

Dental Blue Options Summary of Benefits

Employer Group name: Crouse Hospital - Preventive

Plan Type: Contributory (employer-sponsored)
Product Type: Passive PPO (same coinsurance in & out-of-network)

Plan Features

Network: Reimbursement In network: BlueShield Fee Schedule Reimbursement Out-of-network: East 85% UCR Reimbursement Out of Area: National Dental Network GRID+ DenteMax Reimbursement Out of Area Out-of-network: East 85% UCR	Dependent / student age limit: 19/25
Annual Plan Deductible: $0 Ind / $0 Fam Deductible applies to: Class I services	Annual Plan Maximum per member: $2,500 per member Annual Max applies to: Class I services
Ortho Age Limit: No Coverage Lifetime Orthodontia Maximum: N/A	

Plan Benefits

Type of Care	Benefits Included	Excellus BCBS Pays: In-Network	Excellus BCBS Pays: Out-of-Network
Class I Preventive & Diagnostic	• Cleanings & exams - twice per calendar year • Fluoride treatments – twice per calendar year to age 16 • Sealants – unrestored 1st and 2nd permanent molars, once every 36 months • Bitewing x-rays – up to 4 every calendar year • Full mouth/Panoramic x-rays – once every 36 months • Diagnostic Photograph/Facial Images – once per calendar year • Space maintainers – up to age 16 • Emergency palliative treatment	100%	100%
Class II Basic Restorative	• Fillings – amalgam & composite; each surface covered once every 12 months • Oral surgery – simple extractions	Not Covered	Not Covered
Class IIA Basic Restorative	• Oral surgery – surgical extractions • Endodontics – root canal treatment • Periodontal surgery – osseous surgery, gingivectomy, gingival flap procedure – covered once per quadrant every 36 months • Periodontal scaling & root planing – once per quadrant every 24 months	Not Covered	Not Covered

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Crouse Hospital
Non-Union
Welcome to Davis Vision!

We are pleased to provide you with information on your vision benefit to help you care for your vision and eye health - a key part of overall health and wellness!

If you are not currently enrolled, please visit our member site at davisvision.com or call 1.877.923.2847 and enter client code 5226 to locate providers or for additional information.

DavisVision™

Using your benefits is easy! Just log on to our Member site at davisvision.com and click "Find a Provider," or call us at 1.800.999.5431.

Make an appointment. Tell your provider you are a Davis Vision member with coverage through Crouse Hospital. Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!

Your Davis Vision Designer Plan Benefits

100% OF YOUR CALLS & CLAIMS ARE PROUDLY ADMINISTERED IN THE USA

Benefit	Frequency Once every -	In-network Copay	In-network Coverage
Eye Examination	January 1	$0	Covered in full. *Includes dilation when professionally indicated.*
Spectacle Lenses	January 1	$20	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings.)
Frame	January 1		**Covered in Full Frames:** Any Fashion or Designer level frame from Davis Vision's Collection[1] (retail value, up to $160). **OR, Frame Allowance:** $115 toward any frame from provider.
Contact Lens Evaluation, Fitting & Follow Up Care	January 1	$0	**Davis Vision Collection Contacts**: Covered in full. **Standard, Soft Contacts:** Covered in full.
Contact Lenses (in lieu of eyeglasses)	January 1	$20	**Covered in Full Contacts**: From Davis Vision's Collection[1], after copay, up to: Planned Replacement: Two boxes/multi-packs* Disposable: Four boxes/multi-packs* **OR, Contact Lens Allowance**: $105 allowance toward any contacts from provider's supply. **OR, Visually Required Contacts**: Covered in full with prior approval. *Number of contact lens boxes may vary based on manufacturer's packaging.

Significant savings on optional frames, lens types and coatings! Member Price

Davis Vision Collection Frames: Fashion | Designer | Premier	$0 | $0 | $25
Tinting of Plastic Lenses	$0
Scratch-Resistant Coating	$0
Premium Scratch-Resistant Coating	$30
Ultraviolet Coating	$0
Anti-Reflective Coating: Standard | Premium | Ultra | Ultimate	$35 | $48 | $60 | $85
Polycarbonate Lenses	$0
High-Index Lenses: 1.67 | 1.74	$55 | $120
Progressive Lenses: Standard | Premium | Ultra | Ultimate	$0 | $40 | $90 | $125
Polarized Lenses	$75
Photochromic Lenses (i.e. Transitions®, etc.)[2] Plastic | Glass	$65 | $0
Digital Single Vision Lenses	$0
Blended Lenses	$0
Trivex Lenses	$50
Blue Light Filtering	$15

Additional Savings!

Retinal Imaging	$39

[1] *The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.*

[2] *Transitions® is a registered trademark of Transitions Optical Inc.*

Please note: Your provider reserves the right to not dispense materials until all applicable member costs, fees and copayments have been collected. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the member. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. May not be combined with other discounts or offers. Please be advised these lens options and copayments apply to in-network benefits.

Frequently Asked Questions

How can I contact Member Services?
Call 1.800.999.5431 for automated help 24/7.
(TTY services: 1.800.523.2847.)

What frames are in Davis Vision's Collection?
Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full after your copay. No wonder 8 out of 10 members select a Collection frame. Log on to our member Web site at davisvision.com and take a look!

When will I receive my eyewear?
Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?
Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our member Web site.

Can I split my benefits?
You may split your benefits by receiving your eye examination and eyeglasses or contact lenses on different dates or through different provider locations. To maximize your benefit value we recommend that all services be obtained from a network provider.

Can I use an out-of-network provider?
Yes; however, you receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement, up to the following amounts: eye exam - $30 | single vision lenses - $25 | bifocal - $35 | trifocal - $45 | lenticular - $60 | frame - $30 | elective contacts - $75 | visually required contacts - $225.

Are there any exclusions to the vision benefits?
Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

DAVIS VISION EXTRAS!

One Year Breakage Warranty Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail location where the Collection is not displayed.

Additional Savings Members will receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the provider's usual and customary rate is available. Contact lenses are available at a 10% discount.

Mail Order Contact Lenses Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.

Laser Vision Correction Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisvision.com.

Low Vision Services Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

Eye Health & Wellness Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

For more details... about your vision benefits, patient rights and responsibilities about Davis Vision or to obtain a copy of Davis Vision's Privacy Practices Notice, please log on to our member Web site or contact us at 1.800.999.5431.

Davis Vision has made every effort to correctly summarize your vision plan features herein. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract will prevail.

Benefits administered by Davis Vision, Inc.
Underwritten by Metropolitan Life Insurance Company, New York, NY

voluntary plans	• Periodontal maintenance following surgery – twice per calendar year		
Type of Care	**Benefits Included**	**Excellus BCBS Pays:** **In-Network**	**Out-of-Network**
Class III Major Restorative	• Fixed prosthetics – bridgework, abutments, pontics • Removable prosthetics – partial / complete dentures • Inlays / onlays / crowns – includes coverage for re-cementation • Relines / rebases – once every 36 months and at least 6 months following initial placement • Above services eligible for replacement every 5 years • Implants – eligible for replacement every 10 years, and subject to alternate benefits provision	Not Covered	Not Covered
Class IV Orthodontia	• Initial banding & monthly follow-up treatment • No more than 1/2 the lifetime maximum can be paid in any calendar year	Not Covered	Not Covered

How to Get The Most From Your Plan

Pre-determination of Benefits

Pre-determination of benefits is recommended for any extensive treatment such as periodontics, orthodontics or prosthetics. A description of planned treatment and expected charges should be sent to the Plan before treatment is started. If there is a major change in the treatment, a revised predetermination of benefits is required. The expenses that will be included as Covered Expenses will be determined by your Plan and are subject to the Alternate Benefit provision. When there has not been a predetermination of benefits, your Plan will determine the expenses that will be included as Covered Expenses at the time the claim is received. Predetermination of Benefits does not guarantee payment and expires one year from date of issue. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

Alternate Benefits Provision

All covered procedures are subject to an alternate benefit allowance. When there is more than one technology or material type for a dental procedure, the dental plan will reimburse for the procedure which has the lesser allowance. When alternate benefit is enforced, your benefits are not intended to interfere with the treatment plan recommended by the dentist. You and your dentist should discuss which treatment is best suited for you, and may proceed with the original treatment plan regardless of benefit determination. If the more expensive treatment is chosen, you are liable for the balance up to the billed amount.

Waiting Periods – Timely Entrants

Timely Entrants are those employees that join the plan within 31 days of the following events:During initial open enrollment with Excellus (for new dental groups), As a new hire, After a qualifying event

Participating Dentists

Excellus BlueCross BlueShield offers a broad participating dental network in the Rochester, Syracuse, Utica and surrounding areas. You have the option of receiving care from a dentist of your choice. However, choosing a participating dentist may result in savings for you because participating dentists agree to accept our Schedule of Allowances as payment in full for covered services. Aside from any coinsurance, there is no balance billing for covered services when provided by a participating dentist – that's full coverage with no out-of-pocket expense for your covered routine preventive and diagnostic services.

Non-participating Dentists

You have the freedom to see any dentist. Non-participating dentists are not obligated to accept our Schedule of Allowances. You will be responsible for balances of non-participating dentists' charges.

National Dental Network (if applicable)
In addition to our local network, your Excellus BlueCross BlueShield dental plan gives you access to more dentists nationwide. The national dental network offers coverage in all 50 states, with access to an additional 123,000+ providers across the nation. You have the option of receiving care from a dentist of your choice. Choosing a participating dentist may result in savings for you because participating dentists agree to accept the national dental network Schedule of Allowances as payment for covered services. Aside from any coinsurance, there is no balance billing for covered services when provided by a participating dentist- that's full coverage with no out-of-pocket expense for your covered routine preventive and diagnostic services.

Annual Maximum Rollover Benefit (if applicable)
You can roll over a portion of your unused amount in your annual maximum to the next year if you submit at least one paid dental claim, and do not exceed the rollover threshold. Funds that roll over are added to the next year's annual maximum to be used for future treatment.

Dental Customer Service – for members and dentists
1-800-724-1675
Hours: Monday – Thursday 8:00 am – 5:30 pm
Friday 9:00 am – 5:30 pm

Mailing address for claims
Excellus BCBS
PO Box 21146
Eagan, MN 55121

voluntary plans	• Periodontal maintenance following surgery – twice per calendar year		
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Eagan, MN 55121

Non Union
2025 Employee Contributions - Per Paycheck
Full Time and Part Time Employees working 20 or More Hours Per Week

Medical	Employee	Employee + 1	Family
Crouse Choice Plan	$49.28	$98.56	$179.20
Medical Opt - Out Benefit	$23.00	$23.00	$23.00
Dental	**Employee**	**Employee + 1**	**Family**
Crouse Preventative Dental Plan	$8.46	$17.61	$29.41
Crouse Comprehensive Dental Plan	$16.75	$36.19	$62.77
Dental Opt - Out Benefit	$5.00	$5.00	$5.00
Vision	**Employee**	**Employee + 1**	**Family**
Davis Vision Plan	$5.00	$7.00	$10.00

Per paycheck; there are 26 pay periods annually on a pretax basis