



Union Benefit Summary

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.

For the purposes of benefit eligibility, status is defined as the following:

- **Full-time** - a regularly assigned work schedule of 40 hours during a normal work week.
- **Part-time** - a regularly assigned work schedule of less than 40 hours per week.
- **Part-time with Full-time Benefits (PF)**-a regularly assigned work schedule of 36 hours per week (3/12-hour shifts) that receives full time status benefits.

Paid Time Off

Vacation, sick and personal time are accrued based on hours worked.

HOLIDAYS

- Employees who work on a traditional holiday or reduced staffing day, will be paid time-and one-half for the hours worked (including shift or weekend differential) PLUS holiday pay for the number of hours worked on the normal shift. In the event a Crouse designated holiday falls on the weekend, the holiday will be observed on a reduced staffing day for those departments not open seven (7) days a week. Reduced staffing days will either be a Friday or Monday, depending on what day of the weekend the holiday falls on (i.e. – If Christmas falls on a Saturday, Friday (12/24) is considered the reduced staffing day). For those departments that are open 7 days a week the Holiday will be observed on the traditional day.
- Employees who work both the traditional holiday and the reduced staffing day will be paid the holiday premium for the traditional holiday only.

RN/LPN/Technical Bargaining Unit

Upon completion of the 90 day probationary period, full-time employees are eligible for *6 paid holidays* (or the equivalent of 48 hours) and *6 floating holidays* (or the equivalent of 48 hours).

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas
- 24 hours to be taken by the pay period end date closest to (but before) June 30th
- 24 hours of Floating Holiday time from July 1 through the last pay period in December
- Floating Holidays are pro-rated based on hire date

Service/Maintenance/Clerical Bargaining Unit

Upon completion of the 90 day probationary period, full-time employees are eligible for *7 paid holidays* (or the equivalent of 56 hours) and *5 floating holidays* (or the equivalent of 40 hours).

- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas
- 24 hours to be taken by the pay period end date closest to (but before) June 30th
- 16 hours of Floating Holiday time from July 1 through the last pay period in December
- Floating Holidays are pro-rated based on hire date

PERSONAL LEAVE

- Full-time and part-time employees begin to accrue personal time after the completion of their probationary period.
- Accrual rate is 8 hours for every 693.33 hours worked to a maximum of 24 hours in any rolling 12 month period.
- Employees can accumulate up to a maximum of 48 hours of personal time.

SICK LEAVE

Full-time and part-time employees begin to accrue sick time after 90 calendar days

- Accrual rate is 8 hours for every 173.33 hours worked to a maximum annual benefit of 96 hours in any rolling 12 month period.
- Employees can accumulate up to a maximum of 480 hours of sick leave.

VACATION

Full-time and part-time employees are eligible for accrued time at six (6) months of employment.

- Accruals are based on actual hours worked.
- Maximum accrual is twice the annual benefit.
- After 6 months of employment, employees may borrow one (1) week of paid vacation upon approval from their supervisor, should their accrual not be a full week at that time.

RN/LPN/Technical Bargaining Unit

<i>Examples based on a full-time, 40 hour work week</i>	
Years of Completed Service	Number of Vacation Hours
1 year	80 hours
2 years	88 hours
3 years	96 hours
4 years	104 hours
5 years	112 hours
6 to 10 years	120 hours
11 to 24 years	160 hours
25 years	200 hours

Service and Maintenance/Clerical Bargaining Unit

<i>Examples based on a full-time, 40 hour work week</i>	
Years of Completed Service	Number of Vacation Hours
1 year	80 hours
2 years	88 hours
3 years	96 hours
4 years	104 hours
5 years	112 hours
6 years	120 hours
7 years	128 hours
8 years	136 hours
9 years	144 hours
10 years	152 hours
11 to 24 years	160 hours
25 years	200 hours

PAID PRENATAL LEAVE

Per Diem employees will receive 20 hours of paid time per year (measured in a 52 week period) to be used for prenatal healthcare appointments during pregnancy or related to pregnancy. This will apply to employees who are currently pregnant and those who may be seeking IVF treatments. This is for any prenatal healthcare services related to pregnancy including physical exams, medical procedures, monitoring, testing and discussions with a healthcare provider related to pregnancy, end of pregnancy care and fertility treatments. Health care appointments after pregnancy are not covered by Paid Prenatal Leave.

Additional Paid Time Off

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, grand child, 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, grand child, 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 only 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 for a maximum of 2 weeks.

Health Benefits

- Medical, dental and vision benefits are available to new employees on the 1st of the month following date of hire.
- Benefit selections must be made within 6 days from date of hire.
- All benefit enrollments are for 1 calendar year.
- Employee contributions are deducted pre-tax through payroll deduction.
- Employees can add or modify benefit elections during the annual open enrollment period.

ALLOWABLE BENEFIT CHANGES

- Employees may be 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

GROUP TERM LIFE INSURANCE

- Full-time employees receive a no-cost benefit equal to 3 times their annual salary up to a maximum of \$100,000.
- Part-time employees (working less than 40 hours) receive a no-cost benefit in the amount of \$3,500.

OPTIONAL VOLUNTARY BENEFITS

- Employees can purchase auto, homeowners and pet insurance at discounted rates. Legal insurance can be purchased as well as supplemental life, disability, critical illness and accident coverage. Payroll deduction is offered for all of these benefits.

Disability

SHORT TERM DISABILITY

- Disability leave is available after 4 weeks of employment and can be taken for up to a 26 week benefit.
- There is a 7 day waiting period prior to utilizing this benefit.
- New York State disability law calculates half of the average of the employee's prior eight weeks of gross earnings to a maximum of \$170 per week. Employees contribute \$.60 per week for this disability insurance.
- If you need to apply for disability paperwork or have additional questions, please contact Human Resources at 315-470-7521.

SUPPLEMENTAL SHORT TERM DISABILITY

- Optional short term disability insurance is available for full-time and part-time employees.
- The benefit provides additional compensation for non-work related illness, injury or surgery.

Flexible Spending Accounts

HEALTH CARE REIMBURSEMENT ACCOUNT

- Employees may elect to contribute up to \$3,300 for 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 conveniently deduct expenses by using an electronic debit card at time of purchase.

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.

TRANSPORTATION REIMBURSEMENT ACCOUNT

- Employees may elect to contribute up to \$325 for the 2025 calendar year for parking each calendar year for mass transit to a pre-tax Parking and Transportation Reimbursement Account (expenses for gasoline are not reimbursed through the Transportation Reimbursement Account).
- Crouse Hospital parking is not included as a qualified expense. Any Crouse Hospital parking facility is offered to all employees as a pre-tax deduction.
 - Qualified mass transportation expenses include:
 - Any pass, token, face card, voucher or similar item entitling you to use mass transit to commute to work.

FLEXIBLE SPENDING ACCOUNT CLAIMS GRACE PERIOD

- Claims for expenses that are incurred during any calendar year can be submitted until March 31st of the following year. There is also a grace period extension into the following calendar year which ends 2 months plus 15 days into the next plan year (March 15). During this time frame, participants in the plan may incur expenses and use the funds remaining in their account from the prior year toward eligible FSA expenses. The grace period applies to Healthcare and Dependent Care FSAs.

Retirement Benefits

401(k)

- Employees of Crouse Hospital have the opportunity to contribute a portion of their income, subject to tax code limits, to a 401(k) Plan. Contributions to the 401(k) Plan, as well as interest accumulating are tax deferred—employees do not pay federal income tax on 401(k) savings until they receive benefits. 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.
- Following one (1) year of participation in the plan, the contribution will automatically increase by 1% on the 1st of January following completion of one (1) year. The contribution will increase by 1% each supplemental year up to maximum of 8%.
- After completing one year of service, defined as working at least 1,000 hours in a calendar year, you will be eligible for a 3.5% hospital contribution into your 401(k) Plan. There is a 3 year vesting requirement under the plan for hospital contributions.
- The 401(k) Plan is designed to be a long-term retirement investment program, and as such, withdrawals before age 59 ½ are subject to a 10% tax penalty.
- Employees who terminate their employment with Crouse Hospital can keep their savings in the 401(k) Plan without continuing contributions, transfer or roll over to a new 401(k) or to an Individual Retirement Account (IRA), or receive all or part of the savings subject to income tax and the 10% tax penalty if the employee is under age 59 ½.

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 7:00 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 a.m. - 4:00 p.m. Monday through Friday and can be reached 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 and housed at 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 by calling 315-470-7447 or 1-800-777-6110.

TUITION AID

- All tuition reimbursement benefits are reimbursed through the SEIU 1199 Training and Upgrading Fund.
 - Eligibility requirements:
 - Full-time, part-time or per diem employee averaging at least **24 hours per week**
 - Effective 6/1/2023, must have completed 90 days of service
 - Member of SEIU 1199
- Reimbursement includes coursework with grades of “C” or better.
- Reimbursement for undergraduate courses is up to \$265 per credit hour and graduate courses up to \$425 per credit hour with a maximum of \$3,000 per calendar year.
- Part-time and per diem employees receive an 80% benefit rate.
- Continuing education reimbursement of \$750 per year is available for seminars, workshops, etc.
- Prepaid tuition (voucher program) is also available through participating colleges.
- Tuition reimbursement expenses over \$5,250 in a calendar year are taxable to the employee and are detailed on a 1099.
- Tuition reimbursement and continuing education applications are available in Human Resources or through the Training and Upgrading Fund. For inquiries, please call the Training Fund at 315-424-1743 ext. 154.

TUITION AID FOR CROUSE HOSPITAL COLLEGE OF NURSING

- Full or partial reimbursement is available for employees, their spouses, and any dependent children accepted into the Crouse Hospital College of Nursing.
- Benefits and eligibility are based on the employee's number of years of service on a full- or part-time basis.
 - Full-time employees receive:
 - 0-4 years of service = 50% tuition reimbursement
 - 4+ years of service = 100% tuition reimbursement
 - Part-time employees receive:
 - 4-8 years of service = 50% tuition reimbursement
 - 8+ years of service = 100% tuition reimbursement

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 CAFÉ

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

CORPORATE DISCOUNTS

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

PARKING

- All new employees may sign up for parking at New Employee Orientation.
- Shuttle bus service is available at Crouse Hospital sponsored parking lots.
- Employees may pay for parking (pre-tax) by payroll deduction
- Day shift employees may park in the garage on weekends for five dollars (\$5.00) a day (excluding events).

Pay Enhancements & Shift Benefits

SHIFT DIFFERENTIALS

Hourly employees are paid shift differentials. Shift differential is calculated as a percentage of the base hourly rate as follows:

Shift & Cap	Monday – Friday	Saturday/Sunday
Days % Cap	0%	20% up to \$3.00 per hour
Evenings % Cap	15% up to \$3.50 per hour	30% up to \$5.75 per hour
Nights % Cap	25% up to \$6.00 per hour	30% up to \$6.50 per hour

CALL-TIME PAY

- Employees assigned to be on-call will receive \$6.00 per hour payment for the designated scheduled hours.
- An on-call employee that is physically called-in to the hospital will be required to work a minimum of four hours.
- If the employee is no longer needed after being called-in, they will be paid a minimum of four hours of base pay plus any applicable shift differential. If the employee is notified that the on-call is cancelled before punching in, the employee will receive two hours of pay.
- Registered Nurses, Technologist and Technicians assigned to the following departments will receive twelve dollars (\$12.00) per hour payment for the designated scheduled hours:
 - Cath Lab
 - Interventional Radiology
 - Interventional Radiology Neuro
 - WSC Surgical Suite
 - PACU
 - Anesthesia
 - Endoscopy
 - MRI
 - Ultrasound
 - Nuclear Medicine

OVERTIME PAY

- Hourly employees will be paid time-and-one-half of their regular hourly pay rate for all hours worked in excess of 8, 10 or 12-hour shifts or 40 hours per week.

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.

SHIFT OPTIONS

- 8, 10 and 12 hour shifts are available based on department staffing needs.
- All shift changes are determined by seniority.



CROUSE HOSPITAL - Select Plan

General Information

Cost Sharing Expenses

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Deductible - Single	\$0	\$200	\$200	
Deductible - Family	\$0	\$500	\$500	
Coinsurance	0%	20%	20%	
Annual Out of Pocket Maximum - Single	\$1,000	\$1,000	\$1,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services and Rx Copay. 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	\$3,000	\$3,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services and Rx Copays. RX Out of Pocket Maximum: \$6,000 individual/ \$11,700 family not combined with medical Out-of-Pocket Maximum.

Office Visit Cost Shares

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	20% Coinsurance	20% Coinsurance	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance	20% Coinsurance	20% Coinsurance Subject to Deductible	

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	25% Coinsurance	25% Coinsurance	INN CIF for dependents under 19 yrs of age.
Mental Health Care	Covered in Full	25% Coinsurance	25% Coinsurance	INN CIF for dependents under 19 yrs of age.
Substance Use Detoxification	Covered in Full	25% Coinsurance	25% Coinsurance	INN CIF for dependents under 19 yrs of age.
Skilled Nursing Facility	Covered in Full	Covered in Full	20% Coinsurance	120 Days per confinement
Physical Rehabilitation	Covered in Full	Covered in Full	20% Coinsurance	120 Visits per year Combined INN & OON
Maternity Care	Covered in Full	25% Coinsurance	25% Coinsurance	Certified Birthing Centers 25%, no deductible. INN: CIF for dependents under 19 yrs of age.

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	Covered in Full Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full	

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	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	Covered in Full	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Includes PET scans
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	Covered in Full Subject to Deductible	Covered in Full Subject to Deductible	
Chemotherapy	Covered in Full	Covered in Full Subject to Deductible	Covered in Full Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	Covered in Full	Covered in Full Subject to Deductible	Covered in Full Subject to Deductible	
Mental Health Care	Covered in Full	25% Coinsurance	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	Covered in Full	25% Coinsurance	20% 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	Covered in Full Subject to Deductible	40 Visits per year Visits 41 - 365 Domestic/INN - 20% Coinsurance. OON: 20% Coinsurance, after deductible
Home Infusion Therapy	Covered in Full	Covered in Full	Covered in Full Subject to Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

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 Subject to Deductible	Covered in Full 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 Subject to Deductible	Covered in Full Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Domestic applies to Crouse Physician Network in Offices setting only. Professional interpretation charges domestic/INN CIF and OON is ded/coins
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Domestic applies to Crouse Physician Network in Offices setting only. INN Deductible waived for Genetic Testing. Professional interpretation charges domestic/INN CIF and OON is ded/coins
Radiation Therapy	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full	
Chemotherapy	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% 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.
Maternity Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full	
Telehealth	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Chiropractic Care	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	20 Visits per year Limits combined INN and OON.

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

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	20% 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
Occupational Rehabilitation	20% Coinsurance	20% Coinsurance	20% 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
Speech Rehabilitation	20% Coinsurance	20% Coinsurance	20% 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	20% 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
Occupational Rehabilitation	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% 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
Speech Rehabilitation	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% 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 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	Covered in Full Subject to Deductible	
Routine GYN Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full Subject to Deductible	1 Exam per year
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full 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	20% 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	Covered in Full Subject to Deductible	1 Exam per year
Mammography Screening Facility	Covered in Full	Covered in Full	Covered in Full 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	20% 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	Covered in Full Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full 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	20% 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	Covered in Full 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	20% 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 - 20% Coinsurance	20% Coinsurance Subject to Deductible	Covered through Rx benefit if purchased through pharmacy.
Treatment of Diabetes - Insulin	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	Covered through Rx benefit if purchased through pharmacy.
Diabetic Equipment	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	Covered through Rx benefit if purchased through pharmacy.
Durable Medical Equipment (DME)	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	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	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Covered in Full for Dependents under 19 Emergency no deductible; Domestic CIF for Emergency and Non Emergency Services. Non emergency for INN/OON 20% after ded

Transportation

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	Not Covered	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	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	20% Coinsurance Subject to Deductible	25% 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	Not Covered	Not Covered	Not Covered	Not Covered 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.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Excellus BCBS: Excellus BluePO

A nonprofit independent licensee of the BlueCross BlueShield Association

CROUSE HOSPITAL - Select Plan

Coverage Period: 01/01/2025 - 12/31/2025

Coverage for: Family | Plan Type: PPO



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 visit Our website at www.excellusbcbs.com. 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 www.ccio.cms.gov or 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 <u>deductible</u>?	Preferred Provider: \$0 Individual/N/A Two Person/\$0 Family; Non-Preferred Provider: \$200 Individual/N/A Two Person/\$500 Family; Out-of-Network: \$200 Individual/N/A Two Person/\$500 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes, <u>Preventive Care</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Preferred Provider: \$1,000 Individual/N/A Two Person/\$3,000 Family; Non-Preferred Provider: \$1,000 Individual/N/A Two Person/\$3,000 Family; Out-of-Network: \$1,000 Individual/N/A Two Person/\$3,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	Costs for <u>premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in Preferred Provider network. You pay more if you use a <u>provider</u> in Non-Preferred Provider network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay more)	Out-of-Network 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% Coinsurance	20% Coinsurance Deductible does not apply	20% Coinsurance	None
	Specialist visit	20% Coinsurance	20% Coinsurance Deductible does not apply	20% Coinsurance	
	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: No Charge	
	Diagnostic test (x-ray, blood work)	X-Ray: No Charge Blood Work: No Charge	X-Ray: 20% Coinsurance Blood Work: 20% Coinsurance	X-Ray: 20% Coinsurance Blood Work: 20% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% Coinsurance	20% Coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.excellusbcbs.com/rxlist	Tier 1 (Generic drugs)	\$4/prescription retail, N/A/prescription mail order Deductible does not apply	40% Coinsurance Deductible does not apply	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription Preauthorization required for certain prescription drugs . If you don't get a preauthorization , you must pay the entire cost of the drug. Accelerated approved drugs are not covered unless the manufacturer participates in the Medication Assurance Program.
	Tier 2 (Preferred brand drugs)	\$30/prescription retail, N/A/prescription mail order Deductible does not apply	40% Coinsurance Deductible does not apply	Not Covered	
If you have outpatient surgery	Tier 3 (Non-preferred brand drugs)	\$70/prescription retail, N/A/prescription mail order Deductible does not apply	40% Coinsurance Deductible does not apply	Not Covered	None
	Facility fee (e.g., ambulatory surgery center)	No Charge	20% Coinsurance	20% Coinsurance	
	Physician/surgeon fees	No Charge	No Charge Deductible does not apply	No Charge	

* For more information about limitations and exceptions, see [plan](#) or policy document at www.excellusbcbs.com

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No Charge	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	Not Covered	20% Coinsurance	20% Coinsurance	None
	Urgent care	No Charge	20% Coinsurance	25% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	25% Coinsurance Deductible does not apply	25% Coinsurance Deductible does not apply	None
	Physician/surgeon fees	No Charge	No Charge Deductible does not apply	No Charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	25% Coinsurance Deductible does not apply	20% Coinsurance	None
	Inpatient services	No Charge	25% Coinsurance Deductible does not apply	25% Coinsurance Deductible does not apply	
	Office visits	No Charge	No Charge Deductible does not apply	30% Coinsurance	
If you are pregnant	Childbirth/delivery professional services	No Charge	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Childbirth/delivery facility services	No Charge	25% Coinsurance	25% Coinsurance	
	Home health care	No Charge	No Charge Deductible does not apply	No Charge	
If you need help recovering or have other special health needs	Rehabilitation services	No Charge	20% Coinsurance	20% Coinsurance	45 Visits per year limit
	Habitatation services	No Charge	20% Coinsurance	20% Coinsurance	45 Visits per year limit
	Skilled nursing care	No Charge	No Charge Deductible does not apply	20% Coinsurance Deductible does not apply	25% Coinsurance after 120 day limit
	Durable medical equipment	No Charge	No Charge Deductible does not apply	20% Coinsurance	None
	Hospice services	No Charge	No Charge	No Charge	Family bereavement counseling limited to 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	

* For more information about limitations and exceptions, see [plan](#) or policy document at www.excellsbcbcs.com

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not Covered	Not Covered	Not Covered	

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 ● Dental care (Child) ● Routine eye care (Adult) ● Weight loss programs	● Cosmetic surgery ● Long-term care ● Routine eye care (Child)	● Dental care (Adult) ● Private-duty nursing ● Routine foot care	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
● Bariatric surgery ● Infertility treatment	● Chiropractic care ● Non-emergency care when traveling outside the U.S.	● Hearing aids	

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's 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.

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 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 phone number on Your ID card or www.excellusbcb.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: <https://www.dol.gov/sites/dodgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc> and www.cms.gov/CLIO/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.-----

* For more information about limitations and exceptions, see [plan](#) or policy document at www.excellusbcb.com

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 in-network pre-natal care and a hospital delivery)

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

Total Example Cost	\$12,700
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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 in-network care of a well-controlled condition)

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

Total Example Cost	\$5,600
--------------------	---------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$60
Coinsurance	\$160
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$240

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

Total Example Cost	\$2,800
--------------------	---------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$30
What isn't covered	
Limits or exclusions	\$940
The total Mia would pay is	\$970

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

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

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

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意: 如果您说中文, 我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anviòn la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפּמערקזאַם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אפנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.



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	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.

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	50%	50%
Class IV Orthodontia	- Initial banding & monthly follow-up treatment - No more than 1/2 the lifetime maximum can be paid in any calendar year	50%	50%

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.

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.

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



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	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

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.

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

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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

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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.

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.

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



SERVICE EMPLOYEES BENEFIT FUND (SEBF) DENTAL PLANS

P.O. Box 1240

Syracuse, NY 13201

(315) 218-6513 / (855) 835-9720 Toll Free / (315) 701-0686 Fax

www.sebf.org

Service Employees Benefit Fund (SEBF) offers you and your eligible dependents dental coverage based on a fixed reimbursement schedule with **no Deductibles and a Maximum Benefit of \$1,500 per person, per calendar year.**

SEBF pays 100% of the fixed dollar amounts as outlined on the Dental Schedule of Benefits, subject to the maximum benefit of \$1,500 per person, per calendar year.

There are three dental plans available. For more information, please refer to your collective bargaining agreement for specific details or contact SEBF to determine what you and your dependents are eligible for.

Basic Plan

The Basic Plan includes:

Two Exams, Two Cleanings Per Year, X-rays, Fillings, Extractions, Periodontics (gums) and Endodontics (root canals)

Comprehensive Plan

The Comprehensive Plan includes everything listed under the Basic Dental Plan *plus* the following procedures:

Prosthetics: Crowns, Bridgework, Partial and Full Dentures

Comprehensive with Orthodontia Plan

Includes the Comprehensive Plan *plus* coverage for Orthodontic treatment with a lifetime maximum benefit of \$1,500 for **eligible dependent children up to age 19.**

You can choose any licensed dentist. However, it is to your advantage to choose a Participating Dentist.

If you choose a Participating Dentist:

- Dentist will file your claim(s) with SEBF;
- SEBF will send payment directly to the participating dentist; and
- Dentist agrees to accept the SEBF payment as payment in full for covered services; subject to the maximum benefit of \$1,500 per person, per calendar year.

If you choose a Non-participating Dentist:

- You will be responsible for submitting an itemized bill to SEBF if the dentist doesn't;
- Payment will be made directly to you unless you assign the payment to your dentist. If you authorize the assignment, you are giving SEBF permission to pay the dentist directly instead of sending payment directly to you; and
- Reimbursement will be made according to the SEBF Dental Schedule of Benefits. **You will be responsible for paying the difference between your dentist's charge and SEBF's payment, if any.**

(Over)

Pre-Treatment Estimate

A pre-treatment estimate is when your dental provider submits a treatment plan to SEBF for an estimate of what services will be covered and what SEBF will pay towards those services as well as what the patient's out of pocket will be. This is especially useful for more costly procedures such as crowns, extractions, dentures and periodontal surgery.

A pre-treatment estimate is not a guarantee of payment. When the services are complete and a claim is received for payment, SEBF will calculate its payment based on your current eligibility and amount remaining in your \$1,500 calendar year maximum.

Plan Limitations

- Exams – two per calendar year
- Cleanings – two per calendar year
- Bitewing X-rays – four every 12 months
- Full Mouth or Panorex X-ray – one every three years
- Fluoride for children covered up to age 19
- Sealants for children covered up to age 14
- Periodontal Scaling – two quadrants per visit
- Prosthetics—crowns, bridgework, partial/full dentures are limited to five-year replacement

Plan Exclusions

- Cosmetic services
- Bleaching
- Implants
- Oral Hygiene Instruction
- Infection Control
- Temporary Prosthetics
- Adult Fluoride

Who's Covered?

If you are enrolled for Individual plus One Dependent or Family coverage, SEBF offers benefits for legal spouse, domestic partner* (may be different sex or same sex and you must meet certain requirements) and dependent children. Dependent children will be covered until the 1st day of the month following their 26th birthday.

*Please contact SEBF to verify that your employer allows domestic partner coverage.

Please contact SEBF or visit our website at www.sebf.org if you need:

- A copy of the Dental Schedule of Benefits (most commonly used procedures)
- A copy of the Dental Schedule of Benefits – complete schedule
- A list of the SEBF Participating Dentists
- Domestic partner application
- More information regarding your dental coverage

Service Employees Benefit Fund Representatives are available

Monday through Friday from 8:00 a.m. – 4:00 p.m.

(315) 218-6513

(855) 835-9720 Toll free

(315) 701-0686 Fax

www.sebf.org

The Service Employees Benefit Fund your vision plan

Client code: 6913

Frequency

Exam: 24 mos.

Lenses & lens upgrades: 24 mos.

Frame: 24 mos.

Contacts, evaluation & fitting: 24 mos.



Sign up during
open enrollment

For more details about the plan, visit davisvision.com/member and enter your Client Code or call 1 (877) 923-2847 and enter your Client Code or contact the Service Employees Benefit Fund at 315-218-6513 or Toll Free 1-855-835-9720.



Exams &
Services

Eye Exam copay:

\$10

Contacts evaluation, fitting & follow-up:

Covered in full



Lenses

Lens copay:³

\$25



Frame

Allowance:

\$75

+Additional 20% **off** any overage⁴.

or

The Exclusive Collection copay:

Fashion

Designer

Premier

Covered in full

Covered in full

\$25



Contacts¹
in lieu of glasses

Allowance:

\$100

+Additional 15% **off** any overage⁴.

or

The Exclusive Collection
of Contact Lenses:²

After \$25 copay, covered in full

Using your client code

Log in using your client code (listed above) at davisvision.com/member to find a list of in-network providers near you and access your benefit information.

The Exclusive Collection

The Exclusive Collection of frames is available at nearly 9,000 locations across the U.S. Log in to browse frames, and find a Collection near you.

Free breakage warranty

Your glasses are covered with our FREE one-year breakage warranty. Some limitations apply.

Find a network provider...

Enter your client code in the "Member Sign In" section of our website at davisvision.com/member to locate a provider near you including Visionworks.



Copays for options & upgrades

Lens options

Clear plastic single-vision, bifocal, trifocal or

lenticular lenses (any RX).....	\$0
Polycarbonate Lenses (Children / Adults).....	\$0 or \$30
High-Index Lenses 1.67.....	\$55
High-Index Lenses 1.74.....	\$120
Polarized Lenses.....	\$75
Progressive Lenses (Standard / Premium / Ultra / Ultimate).....	\$50 / \$90 / \$140 / \$175
Anti-Reflective (AR) Coating (Standard / Premium / Ultra / Ultimate).....	\$35 / \$48 / \$60 / \$85
Ultraviolet Coating.....	\$12
Tinting of Plastic Lenses (Solid / Gradient).....	\$0
Plastic Photochromic Lenses (Transitions® Signature™).....	\$65
Scratch-Resistant Coating.....	\$20
Premium Scratch-Resistant Coating.....	\$30
Digital Single Vision Lenses.....	\$30
Trivex Lenses.....	\$50
Blue Light Filtering.....	\$15

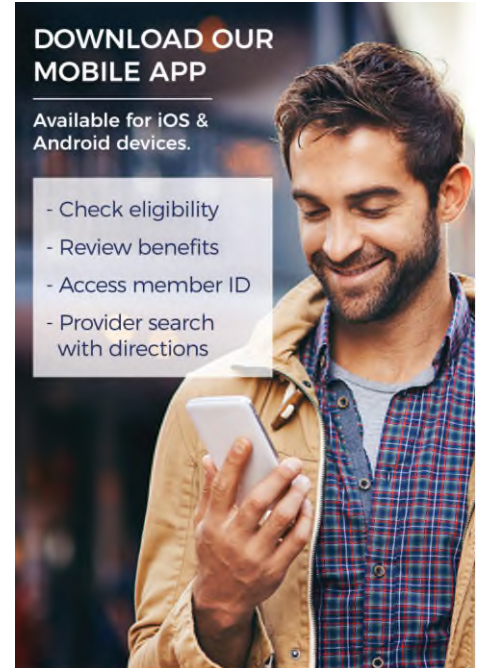
Additional savings

Retinal imaging (Member charge).....	\$39
Additional pairs of eyeglasses.....	30% discount ⁴

DOWNLOAD OUR MOBILE APP

Available for iOS &
Android devices.

- Check eligibility
- Review benefits
- Access member ID
- Provider search with directions



Out-of-network benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network.

Out-of-network reimbursement schedule (up to)

Eye Examination and Materials : \$120

1. Contact lens coverage varies by product selection. Visually Required contacts are covered in full with prior approval. 2. The Davis Vision Exclusive Collection of Contact Lenses is available at participating providers. Evaluation, fitting and follow-up care for Collection contacts are covered in full. 3. The \$25 copay applies to both frames and spectacle lenses. 4. Some limitations apply to additional discounts; discounts not applicable at all in-network providers. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.

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 5227 to locate providers or for additional information.



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



Benefit	Frequency Once every -	In-network Copay	In-network Coverage
Eye Examination	January 1	\$0	Covered in full. <i>Includes dilation when professionally indicated.</i>
Spectacle Lenses	January 1	\$15	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	\$15	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.....	\$20
Premium Scratch-Resistant Coating	\$30
Ultraviolet Coating	\$12
Anti-Reflective Coating: Standard Premium Ultra Ultimate	\$35 \$48 \$60 \$85
Polycarbonate Lenses	\$0 ^{3/} -\$30
High-Index Lenses: 1.67 1.74	\$55 \$120
Progressive Lenses: Standard Premium Ultra Ultimate	\$50 \$90 \$140 \$175
Polarized Lenses	\$75
Photochromic Lenses (i.e. Transitions®, etc.) ^{2/} Plastic Glass	\$65 \$20
Digital Single Vision Lenses	\$30
Blended Lenses.....	\$20
Trivex Lenses	\$50
Blue Light Filtering.....	\$15

Additional Savings!

Retinal Imaging.....	\$39
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^{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.

^{3/} For dependent children, monocular patients and patients with prescriptions of +/- 6.00 diopters or greater.

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

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

Medical	Employee	Employee Plus 1	Family
Crouse Select with Master Medical Plan	\$23.08	NA	\$249.95
Dental	Employee	Employee Plus 1	Family
Crouse Preventative Dental Plan	\$0.00	NA	\$0.00
Crouse Comprehensive Dental Plan	\$11.28	NA	\$43.96
SEBF Basic	\$0.00	\$0.00	\$0.00
SEBF Comprehensive	\$13.08	\$15.92	\$18.75
SEBF Comprehensive (Service & Maint)	\$0.00	\$1.52	\$3.03
Vision	Employee	Employee Plus 1	Family
Davis Vision Plan	\$1.27	\$3.07	\$4.86
SEBF Vision Plan	\$0.00	NA	\$0.00

SEBF Short Term Disability	w/Dental	w/o Dental
	\$10.46	\$12.78

Employee cost for family coverage under the Select with Master Medical Plan for employees earning \$21.00 or less will be as follows:

<u>Rate of Pay</u>	<u>Bi-Weekly Employee Premium Contribution</u>
\$15.00 - \$16.00	\$40.00
\$16.01 - \$17.00	\$50.00
\$17.01 - \$18.00	\$60.00
\$18.01 - \$19.00	\$75.00
\$19.01 - \$20.00	\$85.00
\$20.01 - \$21.00	\$95.00

Employee deductions are taken each pay check on a pre-tax basis 26 times a year.

Union
2025 Employee Contributions - Per Paycheck
Part - Time Employees Working Less than 20 hours per week

Medical	Employee	Employee Plus 1	Family
Crouse Select with Master Medical Plan	\$211.03	NA	\$591.51
Dental	Employee	Employee Plus 1	Family
Crouse Preventative Dental Plan	\$4.37	NA	\$13.75
Crouse Comprehensive Dental Plan	\$20.90	NA	\$63.00
SEBF Basic	\$11.87	\$17.44	\$23.00
SEBF Comprehensive	\$15.75	\$21.38	\$27.00

Vision	Employee	Employee & 1	Family
Davis Vision Plan	\$7.00	\$9.50	\$12.00
SEBF Vision Plan	\$0	NA	\$0

Employee deductions are taken each pay check on a pre-tax basis 26 times a year.