This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.MyPOMCO.com or by calling 1-877-GO1-SU44 (1-877-461-7844). Includes Amendments 2011/001-005.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Level Three** only: $300 individual/ $1,000 family. Does not apply to prescriptions paid through prescription drug manager (PBM), services paid at 100%, and other services as described in your plan document.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You do not have to meet **deductibles** for specific services, but see the chart on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Level One** - $2,000 individual/ $4,000 family; **Level Two** – $4,000 individual /$8,000 family; **Level Three** - $6,000 individual /$12,000 family. These amounts are cumulative across all three Levels. Separate out-of-pocket limit on prescriptions purchased through prescription drug manager (PBM): $2,000 individual/$4,000 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Services paid at 100%, reduced reimbursements for failure to follow pre-authorization, premiums, balance-billed charges, health care this plan does not cover, and other services as described in your plan document.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see www.MyPOMCO.com or call 1-877-GO1-SU44 (1-877-461-7844).	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	Yes, for Level One only.	For Level One, this plan will pay some or all of the costs to see a **specialist** for covered services, but only if you have the plan's permission before you see the **specialist.** For Level Two & Level Three services, you can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 6. See your plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider (Level One & Level Two)	Your cost if you use an Out-of-network Provider (Level Three)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit (Level One); $40 copay/visit then 10% coinsurance (Level Two)	$40 copay/visit then 30% coinsurance	--------none--------
	Specialist visit	$40 copay/visit. Level Two also requires 10% coinsurance	$40 copay/visit then 30% coinsurance	--------none--------
	Other practitioner office visit	$40 copay/visit. Level Two also requires 10% coinsurance	$40 copay/visit then 30% coinsurance	In-network Level Two, and Out-of-network chiropractic care is not covered.
	Preventive care/screening/immunization	No charge	Generally, 30% coinsurance	Limitations and exceptions vary depending on type of service rendered.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider (Level One & Level Two)	Your cost if you use an Out-of-network Provider (Level Three)	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	**X-ray**: $40 copay/visit. Level Two also requires 10% coinsurance. **Blood work**: no charge (Level One); 10% coinsurance (Level Two)	30% coinsurance; x-rays also require $40 copay/visit.	---------none--------
	Imaging (CT/PET scans, MRIs)	$40 copay/visit. Level Two also requires 10% coinsurance	$40 copay/visit then 30% coinsurance	Precertification required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://humanresources.syr.edu/benefits/medical-prescription-drug-plan-options/	Generic drugs	20% coinsurance (retail); $20 copay/prescription (mail order)	Not covered	Limited to 90 day supply (mail order) and 30 day supply (retail). Retail 90 day supply also allowed at retail coinsurance level when using a local participating pharmacy. DAW penalty may apply.
	Preferred brand drugs	25% coinsurance (retail); $50 copay/prescription (mail order)	Not covered	
	Non-preferred brand drugs	45% coinsurance (retail); $90 copay/prescription (mail order)	Not covered	
	Specialty drugs	See mail order copays above	Not covered	Limited to 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 (hospital outpatient) or $150 (ambulatory) copay/visit. Level Two also requires 10% coinsurance	$200 (hospital outpatient) or $150 (ambulatory) copay/visit then 30% coinsurance	---------none--------
	Physician/surgeon fees	No charge (Level One); 10% coinsurance (Level Two)	30% coinsurance	---------none--------
If you need immediate medical attention	Emergency room services	$150 copay/visit		Copay waived if admitted.
	Emergency medical transportation	$100 copay/visit		---------none--------
	Urgent care	$50 copay/visit. Level Two also requires 10% coinsurance	$50 copay/visit then 30% coinsurance	---------none--------

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider (Level One & Level Two)	Your cost if you use an Out-of-network Provider (Level Three)	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay/visit. Level Two also requires 10% coinsurance	$350 copay/visit then 30% coinsurance	Precertification required.
	Physician/surgeon fee	No charge (Level One); 10% coinsurance (Level Two)	30% coinsurance	Physician care limited to one visit/day.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay/visit. Level Two also requires 10% coinsurance	$40 copay/visit then 30% coinsurance	Limited to one visit/day
	Mental/Behavioral health inpatient services	$350 copay/visit. Level Two also requires 10% coinsurance	$350 copay/visit then 30% coinsurance	Precertification required.
	Substance use disorder outpatient services	$40 copay/visit. Level Two also requires 10% coinsurance	$40 copay/visit then 30% coinsurance	---------none--------
	Substance use disorder inpatient services	$350 copay/visit. Level Two also requires 10% coinsurance	$350 copay/visit then 30% coinsurance	Precertification required.
If you are pregnant	Prenatal and postnatal care	No charge (Level One); 10% coinsurance (Level Two)	30% coinsurance	---------none--------
	Delivery and all inpatient services	$350 copay/visit. Level Two also requires 10% coinsurance	$350 copay/visit then 30% coinsurance	---------none--------

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider (Level One & Level Two)	Your cost if you use an Out-of-network Provider (Level Three)	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge (Level One); 10% coinsurance (Level Two)	30% coinsurance	Precertification required.
	Rehabilitation services	$25 copay/visit. Level Two also requires 10% coinsurance	$25 copay/visit then 30% coinsurance	Precertification required for speech & occupational therapy.
	Habilitation services			
	Skilled nursing care	$350 copay/visit. Level Two also requires 10% coinsurance	$350 copay/visit then 30% coinsurance.	Precertification required. Limited to 180 days/ admission or series of admissions not separated by 90 consecutive days.
	Durable medical equipment	10% (Level One) or 20% (Level Two) coinsurance	40% coinsurance	---------none--------
	Hospice service	No charge (Level One); 10% coinsurance (Level Two)	30% coinsurance	Precertification required.
If your child needs dental or eye care	Eye exam	$40 copay/visit (Level One only)	Not covered	Limited to one exam/24 month period.
	Glasses	Not Covered		---------none--------
	Dental check-up	Not Covered		---------none--------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult & child)
- Glasses
- Infertility treatment (facilitation of pregnancy)
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic Care (Level One only)
- Hearing aids
- Non-emergency care when traveling outside the U.S. unless travel is for the sole purpose of obtaining unauthorized medical services
- Private-duty nursing
- Routine eye care (Level One only)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-877-GO1-SU44 (1-877-461-7844). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: POMCO, 2425 James St. Syracuse, NY 13206, Tel. 1-877-GO1-SU44 (1-877-461-7844). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." This health coverage does meet the minimum value standard for the benefits it provides.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,000
- **Patient pays** $540

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$390
Co-insurance	$0
Limits or exclusions	$150
Total	**$540**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,500
- **Patient pays** $900

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$250
Co-insurance	$570
Limits or exclusions	$80
Total	**$900**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.