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.crescenths.com or by calling 800-707-7726.

Important Questions	Answers		Why this Matters:
What is the overall deductible?	**In-Network:** Individual: **$500** Family: **$1,000**	**Out-of-Network:** Individual: **$1,000** Family: **$2,000**	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/SPD 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**.
	Does not apply to copayments, amounts in excess of UCR, services not covered		
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**In-Network:** Individual: **$1,500** Family: **$3,000** Out-of-network applies to in-network amount and vice-versa	**Out-of-Network:** Individual: **$5,000** Family: **$10,000** Out-of-network applies to in-network amount and vice-versa	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties for failing to follow precertification, amounts in excess of UCR, expenses not covered by the plan		Even though you pay these expenses, they don't 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.		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**.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No.	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 doesn't cover are listed below (see Excluded Services & Other Covered Services). See your plan document/SPD for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment/visit	$50 copayment/visit	Deductible does not apply both in-network and out-of-network. Excludes preventive care.
	Specialist visit	$50 copayment/visit	20% coinsurance	Deductible does not apply in-network. Excludes preventive care.
	Other practitioner office visit	20% coinsurance	20% coinsurance	Deductible applies. Chiropractor - Limited to 30 visits per calendar year. Maximum paid benefit of $50 per visit (does not include x-rays).

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No Charge	$50 copayment 20% coinsurance	Deductible does not apply in-network. Maximum paid benefits of $400 per participant per calendar year. Coinsurance and deductible apply to amounts in excess of limit. If in-network, applicable co-payment applies for routine periodic and screening exams. Out-of-network pays 80% after $50 co-payment for most wellness benefits. For immunizations, plan pays 100% (and co-payment does not apply) if performed at the Health Department. Immunizations are not covered otherwise.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge (after $25 copayment)	20% coinsurance	Deductible does not apply in-network
	Imaging (CT/PET scans, MRIs)	No Charge (after $50 copayment)	20% coinsurance	Deductible does not apply in-network
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.crescenths.com	Generic drugs	$10 co-payment / prescription (retail) $20 co-payment / prescription (mail order)	Not Covered	Covers up to a 30-day supply (retail prescriptions). Covers up to a 90-day supply (mail order prescriptions).
	Preferred brand drugs	$35 copayment / prescription (retail) $70 copayment / prescription (mail order)	Not Covered	Covers up to a 30-day supply (retail prescriptions). Covers up to a 90-day supply (mail order prescriptions). Coverage for prescriptions purchased at out-of-network pharmacies are not covered under this plan.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Non-preferred brand drugs	$50 co-payment / prescription (retail) $100 co-payment / prescription (mail order)	Not Covered	Covers up to a 30-day supply (retail prescriptions). Covers up to a 90-day supply (mail order prescriptions). Coverage for prescriptions purchased at out-of-network pharmacies are not covered under this plan.
	Specialty drugs	$50 co-payment / prescription (retail) $100 co-payment / prescription (mail order)	Not covered	Drugs may only be purchased through network pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Deductible applies. Precertification required.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Deductible applies. Precertification required.
If you need immediate medical attention	Emergency room services	$150 copayment	$150 copayment	Separate ER copayment of $150 applies. Deductible does not apply both in-network and out-of-network.
	Emergency medical transportation	10% coinsurance	20% coinsurance	Deductible applies. Includes emergency air transportation.
	Urgent care	$50 copayment	20% coinsurance	Deductible does not apply in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Deductible applies. Precertification required. Payment may be reduced if precertification is not obtained. For out-of-network, plan pays 80% after $250 co-payment per confinement.
	Physician/surgeon fee	10% coinsurance	20% coinsurance	Deductible applies.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	20% coinsurance	Deductible applies.
	Mental/Behavioral health inpatient services	10% coinsurance	20% coinsurance	Deductible applies. Precertification required. Payment may be reduced if precertification is not obtained. If out-of-network, plan pays 80% after $250 co-payment per confinement.
	Substance use disorder outpatient services	10% coinsurance	20% coinsurance	Deductible applies.
	Substance use disorder inpatient services	10% coinsurance	20% coinsurance	Deductible applies. Precertification required. Payment may be reduced if precertification is not obtained. If out-of-network, plan pays 80% after $250 co-payment per confinement.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	20% coinsurance	Deductible applies. Coverage for employee and spouse only.
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	Deductible applies. Precertification required for extended stay. If out-of-network, plan pays 70% after $250 co-payment per confinement.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Deductible applies. Limited to 60 visits per year. Precertification required. Payment may be reduced if precertification is not obtained. Limited to 60 visits per calendar year.
	Rehabilitation services	20% coinsurance	30% coinsurance	Deductible applies. Check with plan for limitations that may apply based on type of therapy. Therapies included: cardiac rehab, occupational, physical, pulmonary/respiratory, speech. Precertification required. If not obtained, payment may be reduced or the service may not be covered. Therapy limited to combined maximum visits of 30 per plan year for occupational, physical, speech, and cardiac rehab.
	Habilitation services	Not Covered	Not Covered	Not covered.
	Skilled nursing care	10% coinsurance	20% coinsurance	Deductible applies. Limited to 60 days per calendar year. Limit of 60 days per calendar year (combined in- and out-of-network.
	Durable medical equipment	20% coinsurance	30% coinsurance	Deductible applies.
	Hospice service	20% coinsurance	30% coinsurance	Deductible applies. Precertification required. Payment may be reduced if precertification is not obtained.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	--------none--------
	Glasses	Not Covered	Not Covered	--------none--------
	Dental check-up	Not Covered	Not Covered	Refer to dental plan

Excluded Services & Other Covered Services:

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

- Acupuncture (for rehabilitation purposes)
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-term Care
- Most Coverage Provided Outside the U.S.
- Non-Emergency Care while Traveling outside the U.S.
- Routine Eye Care (Adult)
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Private Duty Nursing

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 800-707-7726. 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 a plan representative at: 800-707-7726 or visit us at www.crescenths.com. 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.

Additionally, a consumer assistance program may be available in your state to help you with your appeal. Visit www.dol.gov/ebsa/healthreform. Under "Internal Claims and Appeals and External Review", select *Consumer Assistance Programs* for contact information of those states currently offering programs to assist consumers in filing an appeal.

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 Provide Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **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** $5,890
- **Patient pays** $1,650

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	$500
Copays	$0
Coinsurance	$1,000
Limits or exclusions	$150
Total	**$1,650**

These amounts assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not notified the plan, your costs may be higher. For more information, contact 800-707-7726 or visit us at www.crescenths.com.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,820
- **Patient pays** $1,580

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	$500
Copays	$110
Coinsurance	$890
Limits or exclusions	$80
Total	**$1,580**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 800-707-7726 or visit us at www.crescenths.com.

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, copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.