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, go to www.crescenths.com or call 800-707-7726. 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 https://www.healthcare.gov/sbc-glossary or call 800-707-7726 to request a copy.

Important Questions	Answers		Why this Matters:
What is the overall deductible?	**In-Network:** Individual: **$500** Family: **$1,500**	**Out-of-Network:** Individual: **$1,000** Family: **$3,000**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
	Your **deductible** accumulates during the period from 07/01/2017 to 06/30/2018		
Are there services covered before you meet your deductible?	Yes, the following services are covered before you meet your deductible –100% Generic Prescription Drugs, Branded Prescription Drugs, Urgent Care.		This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**In-Network:** Individual: **$3,500** Family: **$10,500**	**Out-of-Network:** Individual: **$7,000** Family: **$21,000**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
	Out-of-network applies to in-network amount and vice-versa.		
What is not included in the out–of–pocket limit?	Premiums, Balance-billing charges, Health care the plan doesn't cover, Penalties for failing to follow precertification, Prescription drug copayments		Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.crescenths.com or call 828-670-9145 for a list of network providers.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from the provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware that your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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	$25 copayment/visit	40% coinsurance (after deductible)	For in-network, Plan pays 100% after $25 copayment up to a maximum benefit of $200 for primary care including all labs and x-rays. Then deductible and coinsurance apply. Maximum payment of $500 per visit. For out-of-network, Plan pays 60%, up to maximum payment of $500 per visit.
	Specialist visit	$50 copayment/visit	40% coinsurance (after deductible)	For in-network, Plan pays 100% after $50 copayment up to a maximum benefit of $400 for specialist care including all labs and x-rays. Then deductible and coinsurance apply. Maximum payment of $1,000 per visit. For out-of-network, Plan pays 60%, up to maximum payment of $1,000 per visit.
	Preventive care/screening/immunization	Plan pays 100% Deductible does not apply	40% coinsurance (after deductible)	For in-network, Plan pays 100% for immunizations, after $25 copayment. . You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance (after deductible)	40% coinsurance (after deductible)	If performed and billed by a physician's office, please see benefits under Primary Care Office Visit and Specialist Office Visit.
	Imaging (CT/PET scans, MRIs)	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Precertification required. If performed and billed by a physician's office, please see benefits under Primary Care Office Visit and Specialist Office Visit.
If you need drugs to treat your illness or condition More information about	Generic drugs	$10 copayment / prescription (30 day retail) $25 copayment / prescription (90 day retail or mail-order)	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
prescription drug coverage is available at www.sonapharmacybenefits.com	Preferred brand drugs	$30 copayment / prescription (30 day retail) $75 copayment / prescription (90 day retail or mail-order)	Not Covered	If a brand drug is dispensed when a generic drug is available, you must pay the difference between the cost of the generic drug and the brand name drug PLUS your applicable copay.
	Non-preferred brand drugs	$60 copayment / prescription (30 day retail) $150 copayment / prescription (90 day retail or mail-order)	Not Covered	If a brand drug is dispensed when a generic drug is available, you must pay the difference between the cost of the generic drug and the brand name drug PLUS your applicable copay.
	Specialty drugs	$60 copayment / prescription (30 day retail) Mail-order not available	Not Covered	For information on ordering specialty medications and dispensing limitation contact Sona Benefits at 1-800-880-9988. Mail order not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Precertification required. Payment may be reduced if precertification is not obtained.
	Physician/surgeon fees	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Precertification required.
If you need immediate medical attention	Emergency room care	20% coinsurance (after $150 copayment/visit)	20% coinsurance (after $150 copayment/visit)	Copayment waived if admitted in-network or out-of-network.
	Emergency medical transportation	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Includes air transportation, if applicable.
	Urgent care	Plan pays 100% (after $30 copayment/visit)	40% coinsurance (after deductible)	Separate facility copayment of $30 applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Precertification required. Payment may be reduced if precertification is not obtained.
	Physician/surgeon fees	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Precertification required. Payment may be reduced if precertification is not obtained.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Plan pays 100% (after $50 copayment/visit)	40% coinsurance (after deductible)	For in-network office visit, Plan pays 100% after $50 copayment up to a maximum benefit of $400 for specialist care including all labs and x-rays. Then deductible and coinsurance apply. Maximum payment of $1,000 per visit. For out-of-network office visit, Plan pays 60%, up to maximum payment of $1,000 per visit.
	Inpatient services	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Precertification required. Payment may be reduced if precertification is not obtained.
If you are pregnant	Office visits	$25 copayment/visit	40% coinsurance (after deductible)	For in-network, Plan pays 100% after $25 copayment up to a maximum benefit of $200 for primary care including all labs and x-rays. Then deductible and coinsurance apply. Maximum payment of $500 per visit. For out-of-network, Plan pays 60%, up to maximum payment of $500 per visit.
	Childbirth/delivery professional services	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Coverage for employee and spouse pregnancies only.
	Childbirth/delivery facility services	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Precertification required for extended stay.
If you need help recovering or have other special health needs	Home health care	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Precertification required. Payment may be reduced if precertification is not obtained.
	Rehabilitation services	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Check with plan for limitations that may apply based on type of therapy. Therapies included: Cardiac Rehabilitation, Occupational, Physical, Pulmonary/ Respiratory, Speech. Precertification required for outpatient rehabilitation.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Limited to 60 days per year. Precertification required. Payment may be reduced if precertification is not obtained.
	Durable medical equipment	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Durable medical equipment includes medical supplies. Precertification required.

* For more information about limitations and exceptions, see the plan or policy document at www.crescenths.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice service	20% coinsurance (after deductible)	40% coinsurance (after deductible)	Precertification required. Payment may be reduced if precertification is not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	See separate Dental Plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Infertility Treatment
- Private Duty Nursing

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: The Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may be available to help you file your appeal. Contact www.dol.gov/ebsa/healthreform for more information.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

* For more information about limitations and exceptions, see the plan or policy document at www.crescenths.com.

is Having a baby (9 months of in-network pre-natal care and a hospital delivery)	
■ **The plan's overall deductible**	**$500**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other copayment**	**$25**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$30
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$3,130**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	**$500**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) copayment**	**$150**
■ **Other coinsurance**	**20%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,000
Coinsurance	$200
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,900**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$500**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) copayment**	**$150**
■ **Other coinsurance**	**20%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$200
The total Mia would pay is	**$1,000**

* For more information about limitations and exceptions, see the plan or policy document at www.crescenths.com.