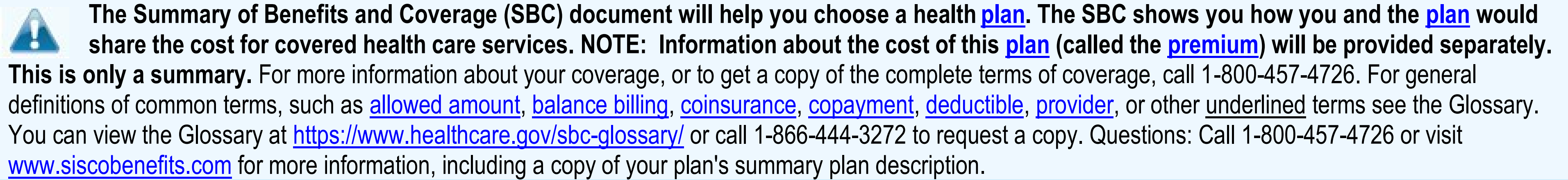
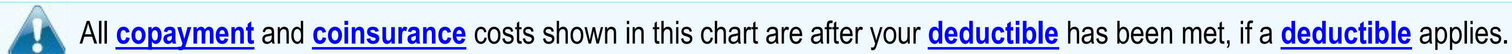


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-457-4726. 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 1-866-444-3272 to request a copy. Questions: Call 1-800-457-4726 or visit www.siscobenefits.com for more information, including a copy of your plan's summary plan description.

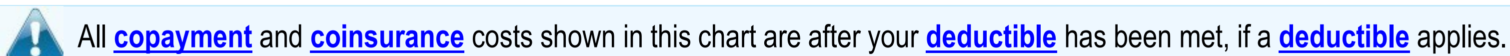
Important Questions	Answers	Why This Matters:
What is the overall deductible?	Crossing Rivers Health: $0 Level 1: $400 / person, $1,200 / family Level 2: $1,000 / person, $3,000 / family Level 3: $1,600 / person, $4,800 / family	Generally, you must pay all of the costs from providers up to the deductible 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.
Are there services covered before you meet your deductible?	Yes. Services received at Crossing Rivers Health; preventive care; emergency care; urgent care; prescription drugs; level 1 office, outpatient physician, and rehabilitation services; and level 1, 2 and 3 chiropractic services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Crossing Rivers Health: $1,700 / person, $2,700 / family Level 1: $2,200 / person, $6,600 / family Level 2: $2,750 / person, $8,250 / family Level 3: $4,000 / person, $12,000 / family	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.
What is not included in the out-of-pocket limit?	Penalties for not pre-certifying services, premiums, balance-billing charges, and health care this plan doesn't cover.	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. Call 1-800-457-4726 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 a provider for the difference between the provider's charge and what

		your plan pays (balance billing). Be aware, 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.



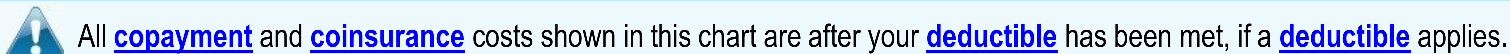
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Crossing Rivers Health Providers (You will pay the least)	Level 1 Providers	Level 2 Providers	Level 3 Providers (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 copay / visit	$25 copay / visit, deductible does not apply	20% coinsurance	30% coinsurance	None
	Specialist visit	$40 copay / visit	$50 copay / visit, deductible does not apply	20% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunizations	No charge	No charge	20% coinsurance, deductible does not apply	30% coinsurance, deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	In conjunction with office visit: 10% coinsurance; Not in conjunction with office visit: $20 copay, 10% coinsurance/visit	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	In conjunction with office visit: 10% coinsurance; Not in conjunction with office visit: $20 copay, 10% coinsurance/visit	20% coinsurance	30% coinsurance	This service requires precertification; If not obtained a penalty of up to $500 may apply.

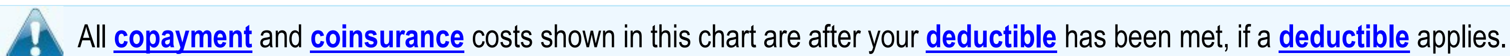


All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

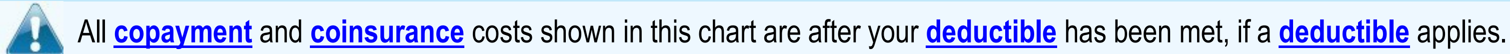
Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Crossing Rivers Health Providers (You will pay the least)	Level 1 Providers	Level 2 Providers	Level 3 Providers (You will pay the most)	
If you need drugs to treat your illness or condition More inform-ation about **prescription drug cover-age** is available at members.medone-rx.com or 888-884-6331	Generic drugs	Purchased at Crossing Rivers Health Pharmacy: $10 copay (30-day supply); $20 copay (31-90 day supply); Purchased at Other Pharmacies: $20 copay (30-day supply); $30 copay (31-90 day supply)				Deductible does not apply to prescription drugs. Up to a 90-day supply of a prescription may be dispensed. Some specialty drugs may be limited to a 30-day supply. If a brand name drug is purchased when a generic equivalent is available, the participant will be responsible for the difference in cost between the brand name and generic drug in addition to the brand name copay. This limitation will not apply if your Physician indicates that only the name brand drug may be used.
	Brand Name drugs	Purchased at Crossing Rivers Health Pharmacy: $25 copay (30-day supply); $35 copay (31-90 day supply); Purchased at Other Pharmacies: $35 copay (30-day supply); $45 copay (31-90 day supply)				
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	NA	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	10% coinsurance	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	Facility: $100 copay / visit; Physician services: 10% coinsurance	Facility: NA; Physician services: 10% coinsurance, deductible does not apply	Facility: $100 copay / visit, deductible does not apply; Physician services: 10% coinsurance, deductible does not apply	Facility: $100 copay / visit, deductible does not apply; Physician services: 10% coinsurance, deductible does not apply	Emergency Care applies to the Crossing Rivers Health out-of-pocket limit. Copay waived if admitted and Inpatientbenefit applies. Non-emergency use of the emergency room received at Level 2 is deductible / 20% coinsurance. Non-emergency use of the emergency room received at Level 3 is deductible / 30% coinsurance.
	Emergency medical transportation	No charge	No charge	No charge	No charge	None



Common Medical Event	Services You May Need	What You Will Pay: Crossing Rivers Health Providers (You will pay the least)	Level 1 Providers	Level 2 Providers	Level 3 Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Urgent care	$50 copay /visit	NA	20% coinsurance, deductible does not apply	30% coinsurance, deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	NA	20% coinsurance	30% coinsurance	In-patient services require precertification: If not obtained up to a $500 penalty may apply. If a facility has only private rooms, the average semi-private rate of the area will be allowed unless a private room is medically necessary. Level 3 facility fee is limited to 90 days per confinement.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	20% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $20 copay / visit; Other Outpatient: 10% coinsurance	Office: $25 copay / visit, deductible does not apply; Other Outpatient: 10% coinsurance	20% coinsurance	30% coinsurance	In-patient services require precertification; If not obtained up to a $500 penalty may apply.
	Inpatient services	Facility: no charge; physician: 10% coinsurance	10% coinsurance	20% coinsurance	30% coinsurance	
If you are pregnant	Office visits	No charge	$25 copay / visit, deductible does not apply	20% coinsurance	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	10% coinsurance	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	No charge	NA	20% coinsurance	30% coinsurance	


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
		Crossing Rivers Health Providers (You will pay the least)	Level 1 Providers	Level 2 Providers	Level 3 Providers (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	NA	20% coinsurance	30% coinsurance	Limited to 50 visits per calendar year combined with Hospice. This service requires precertification; If not obtained up to a penalty of up to $500 may apply.
	Rehabilitation services	No charge	No charge	20% coinsurance	30% coinsurance	Limited to 50 visits per calendar year combined with physical, speech, occupational, athletic and cardiac rehab.
	Habilitation services	$50 copay, 10% coinsurance	10% coinsurance	20% coinsurance	30% coinsurance	Includes physical, occupational, and speech therapies for communication and motor development delays. Requires prior authorization.
	Skilled nursing care	No charge	10% coinsurance	20% coinsurance	30% coinsurance	Limited to 90 days per confinement. If a facility has only private rooms, the average semi-private rate of the area will be allowed unless a private room is medically necessary. In-patient services require precertification; If not obtained up to a $500 penalty may apply.
	Durable medical equipment	No charge	10% coinsurance	20% coinsurance	30% coinsurance	Must be rented/purchased at Crossing Rivers if available. Precertification is required for all rentals and any purchases above $500; If not obtained up to a penalty of $500 may apply.
	Hospice services	No charge	NA	20% coinsurance	30% coinsurance	Limited to 50 visits per calendar year combined with Home Health.


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
		Crossing Rivers Health Providers (You will pay the least)	Level 1 Providers	Level 2 Providers	Level 3 Providers (You will pay the most)	
If your child needs dentalor eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered	None

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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- 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 (limited to 25 visits per calendar year)
- Coverage provided outside the United States. See www.siscobenefits.com
- Hearing aids (covered at Crossing Rivers and Level 1 only)

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 the Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or Ask EBSA at their website (https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa). You may also contact your human resources department for information about continuing your coverage; visit www.siscobenefits.com to find a copy of your plan; or call SISCO at 1-800-457-4726. 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: SISCO at 1-800-457-4726 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or Ask EBSA at their website (https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa).

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 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-457-4726.
Hmong (Hmong): Kev pab nyob rau hauv Hmong hu 1-800-457-4726.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-800-457-4726.
German (Deutsch): Für Hilfe in Deutsch, rufen Sie 1-800-457-4726.
Russian (русский): Для получения помощи на русском языке позвоните по телефону 1-800-457-4726.
Korean (한국어): 한국어로 도움을 받으려면 1-800-457-4726로 전화하십시오
Vietnamese (tiếng Việt): Để được trợ giúp bằng tiếng Việt, xin gọi 1-800-457-4726.
Pennsylvanian Dutch (Deitsch, Pennsylvania Deitsch, Pennsilfaanisch Deitsch): Fer die Hilf in Deitsch, rufe 1-800-457-4726.
Laotian (ລາວ): ສໍາລັບການຊ່ວຍເຫຼືອໃນລາວ, ໃຫ້ໂທຫາ 1-800-457-4726.
French (français): Pour obtenir de l'aide en français, composez le 1-800-457-4726.
Polish (Polish): Aby uzyskać pomoc w języku polskim, zadzwoń pod numer 1-800-457-4726.
Hindi (हिंदी): हिंदी में सहायता के लिए, 1-800-457-4726 पर कॉल करें
Albanian (Albanian): Për ndihmë në thirrjen shqiptare 1-800-457-4726.
Tagalog (Tagalog – Filipino): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-457-4726.
Arabic (عربى): للحصول على المساعدة في اللغة العربية، والدعوة 1-800-457-4726.

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0/$400**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **10%**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$30**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0/$400**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **10%**

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	$850
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$870**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0/$400**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **10%**

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	$200
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$240**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.