CRG Corporation – Copay Plan (Plan 2)

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Coastal Administrative Services: Medical Plan

Coverage Period: 3/1/2026 – 2/28/2027
Coverage for: EE/EE+SP/EE+CH(n)/FAM | **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 CAS at 855-373-8232]. 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.casbenefits.com or call 855-373-8232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: $3,000 individual / $6,000 family For out-of-network providers: $6,000 individual / $12,000 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. Preventive care and primary care 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.	There are no specific deductible amounts before this plan begins to pay for specific services.
What is the out-of-pocket limit for this plan?	For network providers: $6,000 individual / $12,000 family For out- of-network providers: $12,000 individual / $24,000 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?	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. See www.casbenefits.com or call 855-373-8232 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 do not need a referral to see a specialist.	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	$15 copay/office visit deductible waived	50% coinsurance after deductible	None
	Specialist visit	$50 copay/office visit deductible waived	50% coinsurance after deductible	
	Preventive care/screening/ immunization	No charge	50% coinsurance after deductible	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 (blood work)	20% coinsurance after deductible	50% coinsurance after deductible	
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required.
	Diagnostic Imaging (X-rays)	20% coinsurance after deductible	50% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.usrxcare.com	Generic drugs (Tier 1)	$5 copay/prescription (retail)* $12.50 copay/prescription (mail order)**	Not covered	*30-day supply (retail and mail order) **90-day supply (mail order) Covers up to a 30-day retail supply (Exception: Generic drugs can be filled up to a 90-day supply at retail) Covers 30-90-day mail order supply
	Preferred brand drugs (Tier 2)	$50 copay/prescription (retail)* $125 copay/prescription (mail order)**	Not covered	
	Non-preferred brand drugs (Tier 3)	$100 copay/prescription (retail)* $250 copay/prescription (mail order)**	Not covered	
	Specialty drugs (Tier 4)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	

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 immediate medical attention	Emergency room care	$250 copay/visit, then 20% coinsurance after deductible		Copay waived if directly admitted
	Emergency medical transportation	20% coinsurance after deductible		
	Urgent care	$50 copay/office visit deductible waived	50% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required inpatient hospital stays.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit deductible waived	50% coinsurance after deductible	Preauthorization is required for inpatient and partial hospitalization services.
	Inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	
If you are pregnant	Office visits	$15 copay/office visit deductible waived	50% coinsurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 50 visits/Plan Year
	Rehabilitation services	Outpatient : $30 copay/office visit deductible waived Inpatient: 20% coinsurance after deductible	50% coinsurance after deductible	Limited to 30 visits/Plan Year for Cardiac, Occupational, Physical and Speech & Hearing Therapy combined. Limited to 20 visits/Plan Year for Chiropractic Care and Acupuncture combined. Preauthorization is required for inpatient services.
	Habilitation services			
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. Limited to 60 days/ Plan Year.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	
	Hospice services	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. Limited to 180 days/Plan Year

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 your child needs dental or eye care	Children's eye exam	No charge	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge	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.)

- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Weight loss programs
- 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.)

- Chiropractic care (Limited to 20 visits per Plan Year, combined with Acupuncture)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 on how 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: 1-855-373-8232

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-373-8232.

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

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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** **$3,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	**$12,880**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$450
Coinsurance	$1,976
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,486**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$600
Coinsurance	$520
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,180**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$3,000**
- **Emergency room copayment** **$250**
- **Hospital (facility) coinsurance** **20%**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,550
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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