
 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 (the summary plan description), you can visit us at sagafraplans.org/health; or call 1-800-777-4013. 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.ccio.cms.gov; or call 1-800-777-4013 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>The Industry Health Network (TIHN) medical – \$0; In-network medical – \$250 person/\$500 family; Out-of-network medical – \$500 person/\$1,000 family. Separate <u>deductibles</u> for hospital, <u>prescription drugs</u> and dental. <u>Copayments</u> (copays) and <u>coinsurance</u> do not count toward the deductible.</p>	<p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. In-network office visits, in-network <u>preventive care</u>, generic contraceptives, in-network preventive dental and vision (in-network and out-of-network) are covered before you meet your <u>deductible(s)</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes. TIHN hospital – \$150 person/\$300 family; Other in-network hospital – \$250 person/\$500 family; <u>Prescription drugs</u> – \$75 person/\$150 family; Dental – \$75 person/\$200 family.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p>There are <u>coinsurance out-of-pocket limits</u> for: In-network hospital – \$1,750 person/\$3,500 family; In-network medical – \$1,000 person/\$2,000 family; Out-of-network medical – \$2,500 person/\$5,000 family. There is also an overall <u>out-of-pocket limit</u> for in-network hospital, in-network medical and <u>prescription drugs</u> – \$7,150 person/\$14,300 family.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>

<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>The <u>coinsurance out-of-pocket limit</u> excludes: <u>premiums</u>; <u>balance-billing</u> charges; health care this <u>plan</u> doesn't cover; <u>deductibles</u>; <u>copays</u>; <u>coinsurance</u> for <u>prescription drugs</u>, dental and vision.</p> <p>The overall <u>out-of-pocket limit</u> excludes: <u>premiums</u>, <u>balance-billing</u> charges; health care this <u>plan</u> doesn't cover; <u>deductibles</u>, <u>copays</u> and <u>coinsurance</u> for out-of-network medical and for dental and vision.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See www.sagafraplans.org/health or call 1-800-777-4013 for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a provider <u>network</u>. You will pay less if you use a <u>provider</u> in the plan's <u>network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>Yes (for coverage under TIHN only; no referral required for other in-network or out-of-network coverage).</p>	<p>This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> (for coverage under TIHN only; you can see the <u>specialist</u> you choose without a <u>referral</u> for other in-network or out-of-network coverage).</p>

 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	In-network <u>copay</u> does not count toward <u>coinsurance out-of-pocket limit</u> .
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	In-network <u>copay</u> does not count toward <u>coinsurance out-of-pocket limit</u> . A <u>referral</u> is required for TIHN <u>specialists</u> .
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	You may have to pay for in-network services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	<u>Preauthorization</u> is required for sleep studies and neuro-psychological testing. <u>Preauthorization</u> will help you understand what charges may or may not be covered.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.sagafttraplans.org/health or www.express-scripts.com	Generic drugs	Contraceptives – No charge; <u>deductible</u> does not apply; Retail – Greater of \$10 <u>copay/Rx</u> or 10% <u>coinsurance</u> ; Mail order/Walgreens – Greater of \$20 <u>copay/Rx</u> or 10% <u>coinsurance</u> ; maximum <u>copay</u> is \$50/Rx	The in-network <u>copay</u> or <u>coinsurance</u> plus all charges over the amount an in-network pharmacy would have charged	<u>Copays</u> and <u>coinsurance</u> do not count toward <u>coinsurance out-of-pocket limits</u> . Covers up to a 30-day supply for retail; 90-day supply for mail order or any Walgreens Network pharmacy (Walgreens, Duane Reade, Happy Harry's). Long-term drugs starting with the third 30-day fill must be obtained through mail order or from any Walgreens Network pharmacy. <u>Specialty drugs</u> are covered under the applicable <u>copay/coinsurance</u> structure (generic, preferred brand, non-preferred brand), however they must be obtained by mail through the specialty pharmacy, Accredo. No coverage for non- <u>formulary</u> drugs. You pay the difference in cost if you request a brand name drug instead of its generic equivalent (at mail order/Walgreens this cost is in addition to the maximum <u>copay</u> amounts). Some drugs may require <u>preauthorization</u> . If the necessary <u>preauthorization</u> is not obtained, the drug may not be covered. The <u>plan</u> also uses utilization management programs that in certain cases require you to try one or more drugs before another drug will be covered.
	Preferred brand drugs	Retail – Greater of \$25 <u>copay/Rx</u> or 25% <u>coinsurance</u> ; Mail order/Walgreens – Greater of \$50 <u>copay/Rx</u> or 25% <u>coinsurance</u> ; maximum <u>copay</u> is \$125/Rx	The in-network <u>copay</u> or <u>coinsurance</u> plus all charges over the amount an in-network pharmacy would have charged	
	Non-preferred brand drugs	Retail – Greater of \$40 <u>copay/Rx</u> or 40% <u>coinsurance</u> ; Mail order/Walgreens – Greater of \$100 <u>copay/Rx</u> or 40% <u>coinsurance</u> ; maximum <u>copay</u> is \$300/Rx	The in-network <u>copay</u> or <u>coinsurance</u> plus all charges over the amount an in-network pharmacy would have charged	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> /visit plus 10% <u>coinsurance</u>	30% <u>coinsurance</u> plus any charges over \$1,000 for surgical centers and suites	In-network <u>copay</u> does not count toward <u>coinsurance out-of-pocket limit</u> . No coverage for out-of-network hospital charges for outpatient surgery.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	Preauthorization is required for bariatric, gender reassignment, eyelid, breast and nasal surgeries. <u>Preauthorization</u> will help you understand what charges may or may not be covered.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit plus 10% <u>coinsurance</u>	\$100 <u>copay</u> /visit plus 10% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	<u>Copay</u> does not count toward <u>coinsurance out-of-pocket limit</u> . Emergency room <u>copay</u> is waived if immediately confined.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	No coverage for non- <u>emergency medical transportation</u> .
	<u>Urgent care</u>	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	In-network <u>copay</u> does not count toward <u>coinsurance out-of-pocket limit</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copay</u> /admission plus 10% <u>coinsurance</u>	Not covered except for emergencies	<u>Copay</u> does not count toward <u>coinsurance out-of-pocket limit</u> . Emergency treatment at an out-of-network hospital will be covered at the in-network level of benefits.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	Preauthorization is required for organ transplants and bariatric, gender reassignment, eyelid, breast and nasal surgeries. <u>Preauthorization</u> will help you understand what charges may or may not be covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	Office visits – \$25 <u>copay/visit</u> ; <u>deductible</u> does not apply; Other outpatient services – 10% <u>coinsurance</u>	Office visits – 30% <u>coinsurance</u> (based on the <u>plan's allowance</u>); Other outpatient services – 30% <u>coinsurance</u> (based on the <u>plan's allowance</u>)	In-network <u>copays</u> do not count toward <u>coinsurance out-of-pocket limit</u> . Emergency treatment at an out-of-network hospital will be covered at the in-network level of benefits. Residential, partial hospital and intensive outpatient programs are covered as inpatient services (no coverage for out-of-network except for emergencies).
	Inpatient services	\$100 <u>copay/admission</u> plus 10% <u>coinsurance</u>	Not covered except for emergencies	
If you are pregnant	Office visits	Pre-natal – No charge; Postnatal – 10% <u>coinsurance</u>	30% <u>coinsurance</u> (based on the <u>plan's allowance</u>)	In-network <u>copays</u> do not count toward <u>coinsurance out-of-pocket limits</u> . <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copay</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound, which is covered as a <u>diagnostic test</u>). For dependent children, only pre-natal visits at in-network providers and <u>complications of pregnancy</u> are covered.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u> (based on the <u>plan's allowance</u>)	
	Childbirth/delivery facility services	\$100 <u>copay/admission</u> plus 10% <u>coinsurance</u>	Not covered except for emergencies	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u> (based on the <u>plan's allowance</u>)	<u>Preauthorization</u> is required for outpatient private duty nursing, which is limited to 672 hours/year. <u>Preauthorization</u> will help you understand what charges may or may not be covered.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	Physical or occupational therapy – 30% <u>coinsurance</u> plus any charges over \$65/visit; Speech or vision therapy – 30% <u>coinsurance</u> plus any charges over \$55/visit	<u>Rehabilitation/habilitation</u> therapy visits count toward the 12 visit chiropractic and 8 visit acupuncture calendar quarter maximums (see summary plan description page 65).
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>	Not covered	Not covered	Not covered.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	The <u>plan's allowance</u> is limited to the purchase price.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	Must be terminally ill with a life expectancy of less than 12 months.
If your child needs dental or eye care	Children's eye exam	\$10 <u>copay</u> /exam	20% <u>coinsurance</u> plus any charges over \$62.50/exam	1 exam/calendar year. Covered under the VSP benefit. <u>Copay</u> and <u>coinsurance</u> do not count toward the <u>out-of-pocket limit</u> .
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	No charge	25% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	1 exam/6 months. Covered under the Delta Dental benefit.

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.)

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> • Cosmetic surgery • Glasses • Infertility treatment • Learning disabilities • Long-term care | <ul style="list-style-type: none"> • Maternity care for dependent children except prenatal care from in-network providers and <u>complications of pregnancy</u> • Non-emergency treatment at out-of-network hospitals • Orthodontia | <ul style="list-style-type: none"> • Private-duty nursing (inpatient) • <u>Skilled nursing facilities</u> • Surgery to correct refractive errors (e.g. LASIK, PRK, RTK) • Weight loss programs |
|---|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Acupuncture (out-of-network allowance is limited to \$55/visit; maximum 8 visits/calendar quarter; see summary plan description page 65) • Bariatric surgery when preauthorized (minimum BMI of 40; or minimum BMI of 35 with other weight-related conditions) • Chiropractic care (in-network and out-of-network allowance is limited to \$45/visit; maximum 12 visits/calendar quarter; see summary plan description page 65) | <ul style="list-style-type: none"> • Coverage provided outside the United States (including non-emergency care when traveling) • Dental care (adult) – Dental benefits are provided under the Delta Dental benefit, including benefits for children • Hearing aids (maximum payment is \$1,500/device; maximum 1 device/ear/3 year period) | <ul style="list-style-type: none"> • Private duty nursing (outpatient) when preauthorized (limited to 672 hours/year) • Routine eye care (adult) – Vision benefits for eye exams are provided under the VSP benefit, including benefits for children • Routine foot care (removal of corns/calluses or cutting of nails) when medical necessity exists, such as diabetes, neuropathies, etc. |
|---|---|---|

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 U.S. Department of Labor's Employee Benefits Security Administration at 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 [plan](#) at 1-800-777-4013 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-777-4013.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-777-4013.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-777-4013.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-777-4013.

-----*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 \$250
- Specialist copayment N/A
- Hospital (facility) copay/coinsurance \$100/
10%
- 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:

<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$100
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$300
The total Peg would pay is	\$2,000

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

- The plan's overall deductible \$250
- Specialist copayment \$25
- Hospital (facility) copay/coinsurance \$100/
10%
- 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	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$300
Copayments	\$600
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$200
The total Joe would pay is	\$2,100

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

- The plan's overall deductible \$250
- Specialist copayment \$25
- Hospital (facility) copay/coinsurance \$100/
10%
- 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	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$80
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$430

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.