

Benefits Summary - Effective January 1, 2020

Benefit	Plan I		Plan II	
Hospital	In-Network Provider	Out-of-Network Provider	In-Network Provider	Out-of-Network Provider
Calendar Year Deductible	The Industry Health Network - \$150 / person; \$300 / family BlueCard PPO/Beacon Health Options - \$250 / person; \$500 / family	Not covered	The Industry Health Network - \$150 / person; \$300 / family BlueCard PPO/Beacon Health Options - \$500 / person; \$1,000 / family	Not covered
Inpatient (Room and Board and Ancillary Services)	90% of contracted rate after \$100 copay	Not covered*	80% of contracted rate after \$100 copay	Not covered*
Outpatient Surgery	90% of contracted rate after \$100 copay	Not covered	80% of contracted rate after \$100 copay	Not covered
Emergency Room	90% of contract rate after \$100 copay; emergency room copay is waived if immediately confined	Not covered*	80% of contract rate after \$100 copay; emergency room copay is waived if immediately confined	Not covered*
Coinsurance Out-of-Pocket Limit	\$2,750 / person; \$5,500 / family Combined hospital and medical (including MHSA)	Not covered	\$3,200 / person; \$6,400 / family Combined hospital and medical (including MHSA)	Not covered
Medical***	In-Network Provider	Out-of-Network Provider	In-Network Provider	Out-of-Network Provider
Calendar Year Deductible	The Industry Health Network - None BlueCard PPO/Beacon Health Options - \$250 / person; \$500 / family	\$500 / person; \$1,000 / family	The Industry Health Network - None BlueCard PPO/Beacon Health Options - \$500 / person; \$1,000 / family	\$1,000 / person; \$2,000 / family
Office Visit	No deductible; 100% of contract rate after \$25 copay (including LiveHealth Online)**	Medical: 60% of Plan's allowance MHSA: 70% of Plan's allowance	No deductible; 100% of contract rate after \$25 copay (including LiveHealth Online)**	Medical: 50% of Plan's allowance MHSA: 60% of Plan's allowance
Surgeon	90% of contracted rate	60% of Plan's allowance	80% of contracted rate	50% of Plan's allowance
X-ray and Lab	90% of contracted rate	60% of Plan's allowance	80% of contracted rate	50% of Plan's allowance
Therapy (Occupational, Osteopathic, Physical, Speech, Vision)	90% of contracted rate	60% of Plan's allowance	80% of contracted rate	50% of Plan's allowance
Maternity Care - Prenatal Visits	No deductible; 100% of contracted rate	60% of Plan's allowance	No deductible; 100% of contracted rate	50% of Plan's allowance
Delivery	90% of contracted rate	60% of Plan's allowance	80% of contracted rate	50% of Plan's allowance
Routine Physical Exam	No deductible; 100% of contracted rate	60% of Plan's allowance	No deductible; 100% of contracted rate	50% of Plan's allowance
Routine Child Exam	No deductible; 100% of contracted rate	60% of Plan's allowance	No deductible; 100% of contracted rate	50% of Plan's allowance
Routine Mammogram/Pap	No deductible; 100% of contracted rate	60% of Plan's allowance	No deductible; 100% of contracted rate	50% of Plan's allowance
Hearing Aids	90% of contracted rate up to a maximum payment of \$1,500 per device; one device per ear per three-year period	60% of Plan's allowance up to a maximum payment of \$1,500 per device; one device per ear per three-year period	80% of contracted rate up to a maximum payment of \$1,000 per device; one device per ear per three-year period	50% of Plan's allowance up to a maximum payment of \$1,000 per device; one device per ear per three-year period
Coinsurance Out-of-Pocket Limit	\$2,750 / person; \$5,500 / family Combined hospital and medical (including MHSA)	Medical: \$5,000 / person; \$10,000 / family MHSA: \$2,500 / person; \$5,000 / family	\$3,200 / person; \$6,400 / family Combined hospital and medical (including MHSA)	Medical: \$6,000 / person; \$12,000 / family MHSA: \$3,000 / person; \$6,000 / family
Hospital / Medical / Rx Out-of-Pocket Maximum^ (includes Deductibles, Copays, Coinsurance)	\$8,150 / person; \$16,300 / family	None	\$8,150 / person; \$16,300 / family	None

*Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the in-network level of benefits.

**LiveHealth Online is for medical office visit only (not behavioral health).

*** Mental Health and Substance Abuse (MHSA) out-of-network provider services are covered at 70% of Plan's allowance for Plan I and 60% of Plan's allowance for Plan II.

^ Certain specialty medications are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.

Benefits Summary (continued) - Effective January 1, 2020

Benefit	Plan I		Plan II	
Prescription Drugs	Express Scripts Participating Retail Pharmacy	Express Scripts Home Delivery (includes Specialty)	Express Scripts Participating Retail Pharmacy	Express Scripts Home Delivery (includes Specialty)
	<p>Specialty medications must be obtained by mail through the specialty pharmacy, Accredo, beginning with the first fill. Long-term medications must be obtained by mail through the home delivery pharmacy or any Walgreens Network pharmacy beginning with the third fill. Non-formulary drugs are not covered.</p> <p>Certain specialty medications are considered non-essential health benefits* and fall outside the out-of-pocket limits. Therefore, the cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied toward satisfying your out-of-pocket maximums. These non-essential health benefits will have variable copays. A list of non-essential specialty drugs will be provided once it becomes available at www.saveonsp.com/sagafttraplans.</p>		<p>Specialty medications must be obtained by mail through the specialty pharmacy, Accredo, beginning with the first fill. Long-term medications must be obtained by mail through the home delivery pharmacy or any Walgreens Network pharmacy beginning with the third fill. Non-formulary drugs are not covered.</p> <p>Certain specialty medications are considered non-essential health benefits* and fall outside the out-of-pocket limits. Therefore, the cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied toward satisfying your out-of-pocket maximums. These non-essential health benefits will have variable copays. A list of non-essential specialty drugs will be provided once it becomes available at www.saveonsp.com/sagafttraplans.</p>	
Calendar Year Deductible	\$75 / person; \$150 / family		\$175 / person; \$350 / family	
Supply	Up to a 30 day supply / prescription or refill	Up to a 90 day supply / prescription or refill	Up to a 30 day supply / prescription or refill	Up to a 90 day supply / prescription or refill
Copay	The greater of:	The greater of:	The greater of:	The greater of:
Generic	\$10 or 10%	\$20 or 10%; max copay is \$50 / prescription	\$10 or 10%	\$20 or 10%; max copay is \$50 / prescription
Preferred Brand	\$25 or 25%	\$50 or 25%; max copay is \$125 / prescription	\$25 or 25%	\$50 or 25%; max copay is \$125 / prescription
Non-Preferred Brand	\$40 or 40%	\$100 or 40%; max copay is \$300 / prescription	\$40 or 40%	\$100 or 40%; max copay is \$300 / prescription
	<p>In addition, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication.</p> <p>Generic preventive services medications, including contraceptives, are covered at 100% with no deductible or copay.</p>	<p>In addition to the maximum copays listed above, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication.</p> <p>Generic preventive services medications, including contraceptives, are covered at 100% with no deductible or copay.</p>	<p>In addition, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication.</p> <p>Generic preventive services medications, including contraceptives, are covered at 100% with no deductible or copay.</p>	<p>In addition to the maximum copays listed above, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication.</p> <p>Generic preventive services medications, including contraceptives, are covered at 100% with no deductible or copay.</p>
Mental Health and Substance Abuse (MHSA)	Beacon Health Options Provider	Out-of-Network Provider	Beacon Health Options Provider	Out-of-Network Provider
Hospital and Alternative Levels of Care**	Covered under the Hospital Benefit	Not covered***	Covered under the Hospital Benefit	Not covered***
Medical	Covered under the Medical Benefit	Covered under the Medical Benefit	Covered under the Medical Benefit	Covered under the Medical Benefit
Dental	Delta Dental PPO Provider	Delta Premier and Out-of-Network Providers	Delta Dental PPO Provider	Delta Premier and Out-of-Network Providers
Calendar Year Deductible	\$75 / person; \$200 / family	\$75 / person; \$200 / family	\$100 / person; no family maximum	\$100 / person; no family maximum
Diagnostic and Preventive Benefits	No deductible; 100%	75%	No deductible; 100%	60%
Basic Benefits	75%	75%	60%	60%
Major Benefits	50%	50%	50%	50%
Calendar Year Maximum^	\$2,500	\$2,500	\$1,000	\$1,000
Vision - Exam Plus Plan	Vision Service Plan Provider	Out-of-Network Provider	Vision Service Plan Provider	Out-of-Network Provider
Eye Exams	100% after \$10 copay; one exam / calendar year	80% up to maximum payment of \$50; one exam / calendar year	Not covered	
Glasses	20% discount	No benefit		
Professional Services for Contact Lenses	15% discount	No benefit		

*The Affordable Care Act (ACA) defines certain care as essential benefits that must fall under health insurance covered. All other benefits and certain specialty medications are defined as non-essential.

**Alternative levels of care include Residential Treatment Center, Partial Hospital Program and Intensive Outpatient Program.

***Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the in-network level of benefits.

^There is no dental maximum for individuals under age 19.