



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, you can visit us at sagafraplan.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:
What is the overall deductible ?	Combined In-network medical/hospital – \$500 person/\$1,000 family Out-of-network medical – \$500 person/\$1,000 family. Separate deductibles for prescription drugs and dental. Copayments (copays) and coinsurance do not count toward the deductible .	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. In-network office visits, in-network preventive care , generic preventive services medications including contraceptives, in-network preventive dental and vision (in-network and out-of-network) are covered before you meet your deductible(s) .	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?	Yes; Prescription drugs – \$75 person/\$150 family; Dental – \$75 person/\$200 family.	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 ?	There are coinsurance out-of-pocket limits for: In-network combined hospital and medical (including behavioral health) – \$2,750 person/\$5,500 family; There is also an overall out-of-pocket limit for in-network hospital, in-network medical and prescription drugs – \$10,600 person/\$21,200 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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit ?	The coinsurance out-of-pocket limit excludes: premiums ; balance-billing charges; health care this plan doesn't cover; deductibles ; copays ; coinsurance for prescription drugs , dental and vision. The overall out-of-pocket limit excludes: premiums , balance-billing charges; health care this plan doesn't cover; deductibles , copays and coinsurance for out-of-network medical and for dental and vision. Certain specialty drugs 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 limits .	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.sagafraplan.org/health or call 1-800-777-4013 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
		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 copay /visit; deductible does not apply	40% coinsurance (based on the plan's allowance)	In-network copay does not count toward coinsurance out-of-pocket limit .
	Specialist visit	\$25 copay /visit; deductible does not apply	40% coinsurance (based on the plan's allowance)	In-network copay does not count toward coinsurance out-of-pocket limit .

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)	
	Preventive care/screening/immunization	No charge	40% <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.
If you have a test	Diagnostic test (x-ray, blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	<u>Preauthorization</u> is strongly recommended for sleep studies and neuro-psychological testing. <u>Preauthorization</u> will help you understand what charges may or may not be covered. When required by law, out-of-network diagnostic tests will be treated as in-network.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	When required by law, out-of-network imaging will be treated as in-network.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.sagafraplan.org/health	Generic drugs	<u>Preventive services</u> medications, including contraceptives – No charge; <u>deductible</u> does not apply; Retail – Greater of \$10 <u>copay</u> /Rx or 10% <u>coinsurance</u> ; Caremark Home Delivery – Greater of \$20 <u>copay</u> /Rx 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 Caremark Network pharmacy. Long-term drugs starting with the third 30-day fill must be obtained through mail order or from any Caremark Network pharmacy. <u>Specialty drugs</u> must go through mail order. No coverage for <u>non-formulary</u> drugs. You pay the difference in cost if you request a brand name drug instead of its generic equivalent (at Caremark pharmacies/Home Delivery 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</u> /Rx or 25% <u>coinsurance</u> ; Caremark Home Delivery – Greater of \$50 <u>copay</u> /Rx 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</u> /Rx or 40% <u>coinsurance</u> ; Caremark Home Delivery – Greater of \$100 <u>copay</u> /Rx 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	
	Specialty drugs	If enrolled in PrudentRx -- \$0	The in-network <u>copay</u> or	

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)	
		copay (all tiers), otherwise: Generic – 30% Preferred Brand – 30% Non-preferred Brand -30%	<u>coinsurance</u> plus all charges over the amount an in-network pharmacy would have charged	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> /visit plus 10% <u>coinsurance</u>	40% <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>	40% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	<u>Preauthorization</u> is strongly recommended for bariatric, gender reassignment, eyelid, breast, nasal and non-emergency spinal surgeries. <u>Preauthorization</u> will help you understand what charges may or may not be covered. When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need immediate medical attention	Emergency room care	\$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. When required by law, out-of-network emergency room care will be treated as in-network.
	Emergency medical transportation	10% <u>coinsurance</u>	10% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	No coverage for non-emergency medical transportation. When required by law, out-of-network air ambulance transportation will be treated as in-network.
	Urgent care	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <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> . When required by law, out-of-network emergency services provided at urgent care facilities licensed in the state to provide emergency care will be treated as in-network.
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>	40% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	<u>Preauthorization</u> is strongly recommended for organ transplants and bariatric, gender reassignment, eyelid, breast, nasal and non-emergency spinal surgeries. <u>Preauthorization</u> will help you understand what charges may or may not be covered. When required by law, out-of-network physician/surgeon fees will be treated as in-network.

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	Office visits – \$25 <u>copay</u> /visit; <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</u> allowance); Other outpatient services – 30% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	In-network <u>copays</u> do not count toward <u>coinsurance</u> <u>out-of-pocket</u> limit. 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). <u>Preauthorization</u> is strongly recommended for transcranial magnetic stimulation. <u>Preauthorization</u> will help you understand what charges may or may not be covered.
	Inpatient services	\$100 <u>copay</u> /admission 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>	40% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	In-network <u>copays</u> do not count toward <u>coinsurance</u> <u>out-of-pocket</u> limits. <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>	40% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	
	Childbirth/delivery facility services	\$100 <u>copay</u> /admission plus 10% <u>coinsurance</u>	Not covered except for emergencies	
If you need help recovering or have other special health needs	Home health care	10% <u>coinsurance</u>	40% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	<u>Preauthorization</u> is strongly recommended 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.
	Rehabilitation services	10% <u>coinsurance</u>	40% <u>coinsurance</u> (based on the <u>plan's</u> allowance)	Visits for acupuncture and biofeedback will be reviewed for medical necessity after the 20 th visit in a calendar year. Other therapies will be reviewed for medical necessity after the 30 th visit in a calendar year. <u>Pre-authorization</u> is not required but is recommended for visits in excess of these annual amounts.
	Habilitation services			
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	10% <u>coinsurance</u>	40% <u>coinsurance</u>	The <u>plan's</u> allowance is limited to the purchase allowance.

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 services	10% <u>coinsurance</u>	40% <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. In-network <u>copay</u> does not count toward the <u>coinsurance out-of-pocket limit</u> or the overall <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 .)		
• Cosmetic surgery • Glasses • Learning disabilities • Long-term care	• 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	• 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.)		
• Bariatric surgery when preauthorized (minimum BMI of 40; or minimum BMI of 35 with other weight-related conditions) • 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) • Infertility Treatment benefits are limited to \$30,000/lifetime	• 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

[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 1-800-777-4013.]

[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	\$500
■ 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
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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	\$60
The total Peg would pay is	\$1,760

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	\$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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$600
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$160
The total Joe would pay is	\$1,860

Mia's Simple Fracture

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

■ The plan's overall deductible	\$500
■ 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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$75
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$775

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.