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 sagaftraplans.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?	The Industry Health Network (TIHN) medical – $0; In-network medical – $250 person/$500 family; Out-of-network medical – $500 person/$1,000 family. Separate deductibles for hospital, 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. TIHN hospital – $150 person/$300 family; Other in-network hospital – $250 person/$500 family; 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 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 out-of-pocket limit for in-network hospital, in-network medical and prescription drugs – $7,900 person/$15,800 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?	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.	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.sagaftraplans.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?	Yes (for coverage under TIHN only; no referral required for other in-network or out-of-network coverage).	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist (for coverage under TIHN only; you can see the specialist you choose without a referral for other in-network or out-of-network coverage).

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 provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; deductible does not apply	30% 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	30% coinsurance (based on the plan's allowance)	In-network copay does not count toward coinsurance out-of-pocket limit. A referral is required for TIHN specialists.
	Preventive care/screening/ immunization	No charge	30% coinsurance (based on the plan's allowance)	You may have to pay for in-network services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan 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	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance (based on the plan's allowance)	Preauthorization is required for sleep studies and neuro-psychological testing. Preauthorization will help you understand what charges may or may not be covered.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance (based on the plan's allowance)	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.sagaftraplans.org/health or www.express-scripts.com	Generic drugs	Preventive services medications, including contraceptives – No charge; deductible does not apply; Retail – Greater of $10 copay/Rx or 10% coinsurance; Mail order/Walgreens – Greater of $20 copay/Rx or 10% coinsurance; maximum copay is $50/Rx	The in-network copay or coinsurance plus all charges over the amount an in-network pharmacy would have charged	Copays and coinsurance do not count toward coinsurance out-of-pocket limits. 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. Specialty drugs are covered under the applicable copay/coinsurance structure (generic, preferred brand, non-preferred brand), however they must be obtained by mail through the specialty pharmacy, Accredo. No coverage for non-formulary 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 copay amounts). Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered. The plan 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 copay/Rx or 25% coinsurance; Mail order/Walgreens – Greater of $50 copay/Rx or 25% coinsurance; maximum copay is $125/Rx	The in-network copay or coinsurance plus all charges over the amount an in-network pharmacy would have charged	
	Non-preferred brand drugs	Retail – Greater of $40 copay/Rx or 40% coinsurance; Mail order/Walgreens – Greater of $100 copay/Rx or 40% coinsurance; maximum copay is $300/Rx	The in-network copay or coinsurance 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 copay/visit plus 10% coinsurance	30% coinsurance plus any charges over $1,000 for surgical centers and suites	In-network copay does not count toward coinsurance out-of-pocket limit. No coverage for out-of-network hospital charges for outpatient surgery.
	Physician/surgeon fees	10% coinsurance	30% coinsurance (based on the plan's allowance)	Preauthorization is required for bariatric, gender reassignment, eyelid, breast, nasal and non-emergency spinal surgeries. Preauthorization will help you understand what charges may or may not be covered.
If you need immediate medical attention	Emergency room care	$100 copay/visit plus 10% coinsurance	$100 copay/visit plus 10% coinsurance (based on the plan's allowance)	Copay does not count toward coinsurance out-of-pocket limit. Emergency room copay is waived if immediately confined.
	Emergency medical transportation	10% coinsurance	10% coinsurance (based on the plan's allowance)	No coverage for non-emergency medical transportation.
	Urgent care	$25 copay/visit; deductible does not apply	30% coinsurance (based on the plan's allowance)	In-network copay does not count toward coinsurance out-of-pocket limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/admission plus 10% coinsurance	Not covered except for emergencies	Copay does not count toward coinsurance out-of-pocket limit. Emergency treatment at an out-of-network hospital will be covered at the in-network level of benefits.
	Physician/surgeon fees	10% coinsurance	30% coinsurance (based on the plan's allowance)	Preauthorization is required for organ transplants and bariatric, gender reassignment, eyelid, breast, nasal and non-emergency spinal surgeries. Preauthorization 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 copay/visit; deductible does not apply; Other outpatient services – 10% coinsurance	Office visits – 30% coinsurance (based on the plan's allowance); Other outpatient services – 30% coinsurance (based on the plan's allowance)	In-network copays do not count toward coinsurance out-of-pocket 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). Preauthorization is required for transcranial magnetic stimulation. Preauthorization will help you understand what charges may or may not be covered.
	Inpatient services	$100 copay/admission plus 10% coinsurance	Not covered except for emergencies	
If you are pregnant	Office visits	Pre-natal – No charge; Postnatal – 10% coinsurance	30% coinsurance (based on the plan's allowance)	In-network copays do not count toward coinsurance out-of-pocket limits. Cost sharing does not apply for preventive services. Depending on the type of services, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound, which is covered as a diagnostic test). For dependent children, only pre-natal visits at in-network providers and complications of pregnancy are covered.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance (based on the plan's allowance)	
	Childbirth/delivery facility services	$100 copay/admission plus 10% coinsurance	Not covered except for emergencies	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance (based on the plan's allowance)	Preauthorization is required for outpatient private duty nursing, which is limited to 672 hours/year. Preauthorization will help you understand what charges may or may not be covered.
	Rehabilitation services	10% coinsurance	Physical or occupational therapy – 30% coinsurance plus any charges over $65/visit; Speech or vision therapy – 30% coinsurance plus any charges over $55/visit	Rehabilitation/habilitation therapy visits count toward the 12 visit chiropractic and 8 visit acupuncture calendar quarter maximums (see summary plan description page 65).
	Habilitation services			

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)	
	Skilled nursing care	Not covered	Not covered	Not covered.
	Durable medical equipment	10% coinsurance	30% coinsurance	The plan's allowance is limited to the purchase price.
	Hospice services	10% coinsurance	30% coinsurance (based on the plan's 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 copay/exam	20% coinsurance plus any charges over $62.50/exam	1 exam/calendar year. Covered under the VSP benefit. In-network copay does not count toward the coinsurance out-of-pocket limit or the overall out-of-pocket limit.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	No charge	25% coinsurance (based on the plan's 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
- Infertility treatment
- Learning disabilities
- Long-term care
- Maternity care for dependent children except prenatal care from in-network providers and complications of pregnancy
- Non-emergency treatment at out-of-network hospitals
- Orthodontia
- Private-duty nursing (inpatient)
- Skilled nursing facilities
- 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.)

- 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)
- 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)
- 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, kwiijigo 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:

Cost Sharing	
Deductibles*	$500
Copayments	$100
Coinsurance	$1,100
What isn't covered	
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:

Cost Sharing	
Deductibles*	$300
Copayments	$600
Coinsurance	$1,000
What isn't covered	
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:

Cost Sharing	
Deductibles	$250
Copayments	$80
Coinsurance	$100
What isn't covered	
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.

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