This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.sagph.org or by calling 1-800-777-4013.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	The Industry Health Network (TIHN) medical – No deductible; Network medical – **$250** person**/$500** family; Non-network medical – **$500** person**/$1,000** family. No deductible for preventive care and vision. Separate deductibles for hospital, prescription drugs and dental. Copays and coinsurance do not count toward the ded.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. TIHN hospital – **$150** person**/$300** family; Hospital – **$250** person**/$500** family; Prescription drugs – **$150** person**/$300** family; Dental – **$75** person**/$200** family. No ded. for generic contraceptives and net. prev. dental.	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.
Is there an out–of–pocket limit on my expenses?	Yes. There are coinsurance out-of-pocket limits for: Hospital – **$1,750** person**/$3,500** family; Network medical – **$1,000** person**/$2,000** family; Non-network medical – **$2,500** person**/$5,000** family. There is also an overall out-of-pocket limit for hospital, network medical and prescription drugs – **$6,850** person**/$13,700** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums; balance-billed charges; non-covered expenses; deductibles; copays; coinsurance for prescription drugs, dental and vision. The overall out-of-pocket limit excludes: premiums; balance-billed charges; non-covered expenses; deductibles, copays and coinsurance for non-network medical and for dental and vision.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.sagph.org or call 1-800-777-4013 for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	Yes. TIHN – You need a written referral. Other network or non-network – No.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit plus 10% coinsurance	$15 copay/visit plus 30% coinsurance	----------none----------
	Specialist visit	$15 copay/visit plus 10% coinsurance	$15 copay/visit plus 30% coinsurance	A referral is required for TIHN specialists.
	Other practitioner office visit	Chiropractic – $15 copay/visit plus 10% coinsurance plus any charges over $45/visit; Other practitioners – $15 copay/visit plus 10% coinsurance	$15 copay/visit plus 30% coinsurance plus any charges over: $55/visit for acupuncture; $45/visit for chiropractic	The Plan will not consider more than 12 visits/calendar quarter for chiropractic treatment or 8 visits/calendar quarter for acupuncture. Chiropractic visits count toward the acupuncture maximum and vice versa. Rehabilitation/habilitation therapy visits also count toward the 12 and 8 visit maximums.
	Preventive care/ screening/immunization	No charge	Preventive care - $15 copay/ visit plus 30% coinsurance; Screening*/immunization – 30% coinsurance	As required by the Affordable Care Act. *The copay for outpatient surgery applies to colonoscopies (see page 3).
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Sleep studies must be preauthorized by the Plan Office.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.sagph.org or www.express-scripts.com.	Generic drugs	Contraceptives – No charge; Retail – Greater of $10 copay or 10% coinsurance; Mail order – Greater of $20 copay or 10% coinsurance; maximum mail order copay is $50/prescription	The network copay plus all charges over the amount a network pharmacy would have charged	Covers up to a 30 day supply for retail; covers up to a 90 day supply for mail order. You pay the difference in cost if you request a brand name drug instead of its generic equivalent (at mail order this cost is limited 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. Specialty medications must be obtained by mail through the specialty pharmacy, Accredo. Non-formulary drugs are not covered.
	Preferred brand drugs	Retail – Greater of $25 copay or 25% coinsurance; Mail order – Greater of $50 copay or 25% coinsurance; maximum mail order copay is $125/prescription	The network copay plus all charges over the amount a network pharmacy would have charged	
	Non-preferred brand drugs	Retail – Greater of $40 copay or 40% coinsurance; Mail order – Greater of $100 copay or 40% coinsurance; maximum mail order copay is $300/prescription	The network copay plus all charges over the amount a network pharmacy would have charged	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance plus any charges over $1,000 for surgical centers and suites	Non-network hospital charges for outpatient surgery are not covered.
	Physician/surgeon fees	Doctor's office – $15 copay plus 10% coinsurance; Outpatient hospital/surgical center/surgical suite – $100 copay plus 10% coinsurance	Doctor's office - $15 copay plus 30% coinsurance; Outpatient hospital/surgical center/surgical suite - $100 copay plus 30% coinsurance	Bariatric, eyelid, breast and nasal surgeries must be preauthorized by the Plan Office.
If you need immediate medical attention	Emergency room services	$100 copay/visit plus 10% coinsurance	$100 copay/visit plus 10% coinsurance	Copay is waived if immediately confined.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Non-emergency medical transportation is not covered.
	Urgent care	$15 copay/visit plus 10% coinsurance	$15 copay/visit plus 30% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered except for emergencies	Emergency treatment at a non-network hospital will be covered at the network level of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Physician/surgeon fee	Inpatient surgery – $100 copay plus 10% coinsurance; All other – 10% coinsurance	Inpatient surgery - $100 copay plus 30% coinsurance; All other – 30% coinsurance	Organ transplants and bariatric, eyelid, breast and nasal surgeries must be preauthorized by the Plan Office.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay/visit plus 10% coinsurance	$15 copay/visit plus 30% coinsurance	Emergency treatment at a non-network hospital will be covered at the network level of benefits. Residential, partial hospital and intensive outpatient programs are covered as inpatient services.
	Mental/Behavioral health inpatient services	10% coinsurance	Not covered except for emergencies	
	Substance use disorder outpatient services	$15 copay/visit plus 10% coinsurance	$15 copay/visit plus 30% coinsurance	
	Substance use disorder inpatient services	10% coinsurance	Not covered except for emergencies	
If you are pregnant	Prenatal and postnatal care	Prenatal – No charge; Postnatal – 10% coinsurance	30% coinsurance	Ultrasounds will be covered as diagnostic tests.
	Delivery and all inpatient services	$100 copay/delivery plus 10% coinsurance	Professional charges – $100 copay/delivery plus 30% coinsurance; Hospital charges – Not covered except for emergencies	Emergency treatment at a non-network hospital will be covered at the network level of benefits.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Outpatient private duty nursing must be preauthorized and is limited to 672 hours/year.
	Rehabilitation services	$15 copay/visit plus 10% coinsurance	$15 copay/visit plus 30% coinsurance plus any charges over: $65/visit for physical or occupational therapy; $55/visit for speech or vision therapy	Rehabilitation/habilitation therapy visits count toward the 12 visit chiropractic and 8 visit acupuncture calendar quarter maximums.
	Habilitation services			
	Skilled nursing care	Not covered	Not covered	Not covered.
	Durable medical equipment	10% coinsurance	30% coinsurance	Allowable charges are limited to the purchase price.
	Hospice service	10% coinsurance	30% coinsurance	Must be terminally ill with a life expectancy of less than 12 months.
If your child needs dental or eye care	Eye exam	$10 copay/exam	20% coinsurance plus any charges over $62.50/exam	1 exam/calendar year. Covered under the VSP benefit.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	No charge	25% coinsurance	1 exam/6 months. Covered under the Delta Dental benefit.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery	• Long-term care	• Skilled nursing facilities
• Glasses	• Non-emergency treatment at non-network hospitals	• Surgery to correct refractive errors (e.g. LASIK, PRK, RTK)
• Infertility treatment	• Orthodontia	• Weight loss programs
• Learning disabilities	• Private-duty nursing (inpatient)	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture (maximum 8 visits/calendar quarter – see page 2)	• Coverage provided outside the United States	• Private duty nursing (outpatient) when preauthorized (limited to 672 hours/year)
• Bariatric surgery when preauthorized (minimum BMI of 40; or minimum BMI of 35 with other weight-related conditions)	• Dental care (children and adults) – Dental benefits are provided under the Delta Dental benefit.	• Routine eye care (children and adults) – Vision benefits for eye exams are provided under the VSP benefit.
• Chiropractic care (maximum 12 visits/calendar quarter – see page 2)	• Hearing Aids (maximum payment is $1,500/device; maximum 1 device/ear/3 year period)	• 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:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-777-4013. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. **The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,140
- **Patient pays** $1,400

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$100
Coinsurance	$600
Limits or exclusions	$200
Total	**$1,400**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,000
- **Patient pays** $1,400

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$400
Copays	$500
Coinsurance	$300
Limits or exclusions	$200
Total	**$1,400**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.