

 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, [www.deltahealthsystems.com](http://www.deltahealthsystems.com). 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.deltahealthsystems.com](http://www.deltahealthsystems.com) or call 1-800-464-7627 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>PPO:</b> \$1,000 Individual / \$2,000 Family <b>Non-PPO:</b> \$2,000 Individual / \$4,000 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive</a> care, physician office visits, emergency room, ambulance, acupuncture, hearing exam, and medication management are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>PPO:</b> \$5,000 Individual / \$10,000 Family <b>Prescription</b> \$1,000 Individual/ \$2,000 Family <b>Non-PPO:</b> \$10,000 Individual / \$20,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">participating provider</a> ?	Yes. See <a href="http://www.tcsig.com">www.tcsig.com</a> or call Delta Health Systems at 1-800-464-7627 for a list of <a href="#">PPO Providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use a <a href="#">Non-PPO provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">PPO Provider</a> might use a <a href="#">Non-PPO provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">Copay</a>	50% <a href="#">Coinsurance</a>	-----none-----  You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	<a href="#">Specialist</a> visit			
	<a href="#">Preventive care/screening/immunization</a>	No charge		
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ProActrx.com">www.ProActrx.com</a> . 877-635-9545	Generic drugs	\$5 <a href="#">Copay</a> / prescription (Retail) \$10 <a href="#">Copay</a> / prescription (Mail Order & other retail)	Not Covered	Prescriptions are not covered when accessing a Non-Network Pharmacy or Non-Contracted Mail Order company.  A list of <a href="#">Network</a> pharmacies is available at <a href="http://www.ProActrx.com">www.ProActrx.com</a>  Retail: 31-day supply Requires the use of a <a href="#">Network</a> Pharmacy.  Mail Order and other retail: 90-day supply. Requires the use of the contracted Mail Order company.
	Preferred brand drugs	25% <a href="#">Coinsurance</a> up to \$35 / prescription (Retail) \$50 <a href="#">Copay</a> / prescription (Mail Order & other retail)		
	Non-Preferred brand drugs	45% <a href="#">Coinsurance</a> up to \$70 / prescription (Retail) \$90 <a href="#">Copay</a> / prescription (Mail Order & other retail)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	-----none-----

\* For more information about limitations and exceptions, see the plan or policy document at [www.deltahealthsystems.com](http://www.deltahealthsystems.com)

 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
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
	Physician/surgeon fees	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <u>Copay</u> + 30% <u>Coinsurance</u>		-----none-----
	<a href="#">Emergency medical transportation</a>	30% <u>Coinsurance</u> <u>Deductible</u> does not apply		Non-PPO non emergent transportation: 50% <u>coinsurance</u>
	<a href="#">Urgent care</a>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required or benefits will be reduced by 50%.
	Physician/surgeon fees	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required or benefits will be reduced by 50%.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% <u>Coinsurance</u> Up to \$50 max	50% <u>Coinsurance</u> Up to \$25 max	Pre-certification is required or benefits will be reduced by 50%. Combined maximum of 52 visits per calendar for in and outpatient Mental Health and Substance abuse services.
	Inpatient services	30% <u>Coinsurance</u>	Not Covered	Pre-certification is required or benefits will be reduced by 50%. Combined maximum of 30 days per calendar year up to 90 days per lifetime.
If you are pregnant	Office visits	\$20 <u>Copay</u>	50% <u>Coinsurance</u>	-----none-----
	Childbirth/delivery professional services	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	-----none-----
	Childbirth/delivery facility services	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	-----none-----

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 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
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required or benefits will be reduced by 50%. Limited to 100 visits per calendar year.
	<a href="#">Rehabilitation services</a>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	-----none-----
	<a href="#">Habilitation services</a>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Limited to 20 visits per calendar year.
	<a href="#">Skilled nursing care</a>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required or benefits will be reduced by 50%. Limited to 100 days per calendar year.
	<a href="#">Durable medical equipment</a>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required for billed charges in excess of \$2,000, or benefits will be reduced by 50%.
	<a href="#">Hospice services</a>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required or benefits will be reduced by 50%.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	-----none-----

\* For more information about limitations and exceptions, see the plan or policy document at [www.deltahealthsystems.com](http://www.deltahealthsystems.com)

## 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"><li>• Bariatric surgery</li><li>• Dental care (Adult)</li><li>• Hearing aids</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Private duty nurse</li><li>• Routine eye care (Adult)</li><li>• Routine foot care</li></ul> | <ul style="list-style-type: none"><li>• Weight loss programs</li></ul> |
|--|---|---|--|

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

- Acupuncture
- Chiropractic care
- Cosmetic surgery (limited)

**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 plan at 1-800-464-7627, the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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 1-800-464-7627. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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:

Español: Para obtener asistencia en Español, llame al 1-888-212-1231.

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-212-1231.

中文: 如果需要中文的帮助, 请拨打这个号码1-888-212-1231.

Dine: Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-212-1231.

-----*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](#) \$1000
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$20
Coinsurance	\$3,448
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,528</b>

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

- The [plan's](#) overall [deductible](#) \$1000
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$455
Coinsurance	\$794
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,304</b>

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

- The [plan's](#) overall [deductible](#) \$1000
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$108
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,108</b>