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. 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 or call 1-800-464-7627 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO: $500 Individual / $1,000 Family Non-PPO: $1,000 Individual / $2,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, physician office visits, emergency room, ambulance, acupuncture, hearing exam, and medication management are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	PPO: $2,500 Individual / $5,000 Family Prescription $1,000 Individual/ $2,000 Family Non-PPO: $4,000 Individual / $8,000 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?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a participating provider?	Yes. See www.tcsig.com or call Delta Health Systems at 1-800-464-7627 for a list of PPO 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 a Non-PPO 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 PPO Provider might use a Non-PPO 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
		PPO Provider (You will pay the least)	Non-PPO 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	$15 Copay	30% Coinsurance	----------none----------
	Specialist visit			
	Preventive care/screening/ immunization	No charge		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.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	30% Coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ProActrx.com . 877-635-9545	Generic drugs	$5 Copay / prescription (Retail) $10 Copay / 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 Network pharmacies is available at www.ProActrx.com Retail: 31-day supply Requires the use of a Network Pharmacy. Mail Order and other retail: 90-day supply. Requires the use of the contracted Mail Order company.
	Preferred brand drugs	25% Coinsurance up to $35 / prescription (Retail) $50 Copay / prescription (Mail Order & other retail)	Not Covered	
	Non-Preferred brand drugs	45% Coinsurance up to $70 / prescription (Retail) $90 Copay / prescription (Mail Order & other retail)	Not Covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	----------none----------
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	$50 Copay + 10% Coinsurance		----------none----------
	Emergency medical transportation	10% Coinsurance Deductible does not apply		Non-PPO non emergent transportation: 30% coinsurance.
	Urgent care	10% Coinsurance	30% Coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	30% Coinsurance	Pre-certification is required or benefits will be reduced by 50%.
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	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% Coinsurance up to $50 visit max.	50% Coinsurance up to $25 visit 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	10% Coinsurance	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	$15 Copay	30% Coinsurance	----------none----------
	Childbirth/delivery professional services	10% Coinsurance	30% Coinsurance	----------none----------

* For more information about limitations and exceptions, see the plan or policy document at 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)	
	Childbirth/delivery facility services	10% Coinsurance	30% Coinsurance	----------none----------
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	30% Coinsurance	Pre-certification is required or benefits will be reduced by 50%. Limited to 100 visits per calendar year.
	Rehabilitation services	10% Coinsurance	30% Coinsurance	----------none----------
	Habilitation services	10% Coinsurance	30% Coinsurance	Limited to 20 visits per calendar year.
	Skilled nursing care	10% Coinsurance	30% Coinsurance	Pre-certification is required or benefits will be reduced by 50%. Limited to 100 days per calendar year.
	Durable medical equipment	10% Coinsurance	30% Coinsurance	Pre-certification is required for billed charges in excess of $2,000, or benefits will be reduced by 50%.
	Hospice services	10% Coinsurance	30% Coinsurance	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----------

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.)			
• Bariatric surgery	• Infertility treatment	• Private duty nurse	
• Dental care (Adult)	• Long term care	• Routine eye care (Adult)	• Weight loss programs
• Hearing aids	• Non-emergency care when traveling outside the U.S.	• Routine foot care	

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. 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 1-800-464-7627. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 1-800-464-7627.

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-464-7627.

中文: 如果需要中文的帮助，请拨打这个号码1-800-464-7627.

Dine: Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-464-7627.

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 *copay*	$15
Hospital (facility) *coinsurance*	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	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$1,199
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,779

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 *copay*	$15
Hospital (facility) *coinsurance*	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	$7,389

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$440
Coinsurance	$474
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,469

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

The plan's overall deductible	$500
Specialist *copay*	$15
Hospital (facility) *coinsurance*	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	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$80
Coinsurance	$47
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$627

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