

 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: \$150 Individual / \$300 Family Non-PPO: \$300 Individual / \$600 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: \$950 Individual / \$1,900 Family Prescription \$1,000 Individual/ \$2,000 Family Non-PPO: \$1,600 Individual / \$3,200 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.
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	\$10 Copay	40% Coinsurance	-----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.
	Specialist visit			
	Preventive care/screening/immunization	No charge		
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% 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	

* 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)	
	Specialty drugs	Not Covered	Not Covered	-----none-----
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	-----none-----
	Physician/surgeon fees	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	-----none-----
If you need immediate medical attention	Emergency room care	\$50 <u>Copay</u> + 20% <u>Coinsurance</u>		-----none-----
	Emergency medical transportation	20% <u>Coinsurance</u> <u>Deductible</u> does not apply		Non-PPO non emergent transportation: 40% <u>coinsurance</u>
	Urgent care	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Pre-certification is required or benefits will be reduced by 50%.
	Physician/surgeon fees	20% <u>Coinsurance</u>	40% <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 visit max	50% <u>Coinsurance</u> 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	20% <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	\$10 <u>Copay</u>	40% <u>Coinsurance</u>	-----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 professional services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	-----none-----
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	-----none-----
If you need help recovering or have other special health needs	Home health care	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Pre-certification is required or benefits will be reduced by 50%. Limited to 100 visits per calendar year.
	Rehabilitation services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	-----none-----
	Habilitation services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to 20 visits per calendar year.
	Skilled nursing care	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Pre-certification is required or benefits will be reduced by 50%. Limited to 100 days per calendar year.
	Durable medical equipment	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Pre-certification is required for billed charges in excess of \$2,000, or benefits will be reduced by 50%.
	Hospice services	20% <u>Coinsurance</u>	40% <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

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.)

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|---------------|---------------------|------------------------------|
| • Acupuncture | • Chiropractic care | • Cosmetic surgery (limited) |
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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, kwijigo 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	\$150
■ Specialist copay	\$10
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$0
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,010

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$150
■ Specialist copay	\$10
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$338
Coinsurance	\$462
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$4,055

Mia's Simple Fracture

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

■ The plan's overall deductible	\$150
■ Specialist copay	\$10
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$70
Coinsurance	\$170
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$390