





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: \$750 Individual / \$1,500 Family</b> <b>Non-PPO: \$1,500 Individual / \$3,000 Family</b>	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: \$3,500 Individual / \$7,000 Family</b> <b>Prescription \$1,000 Individual/ \$2,000 Family</b> <b>Non-PPO: \$7,000 Individual / \$14,000 Family</b>	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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>Copay</u>	40% <u>Coinsurance</u>	-----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.
	<u>Specialist</u> visit			
	<u>Preventive care/screening/immunization</u>	No charge		
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.ProActrx.com">www.ProActrx.com</a> . 877-635-9545	Generic drugs	\$5 <u>Copay</u> / prescription (Retail) \$10 <u>Copay</u> / 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 <u>Network</u> pharmacies is available at <a href="http://www.Proactrx.com">www.Proactrx.com</a>  Retail: 31-day supply Requires the use of a <u>Network</u> Pharmacy.  Mail Order and other retail: 90-day supply. Requires the use of the contracted Mail Order company.
	Preferred brand drugs	25% <u>Coinsurance</u> up to \$35 / prescription (Retail) \$50 <u>Copay</u> / prescription (Mail Order & other retail)		
	Non-Preferred brand drugs	45% <u>Coinsurance</u> up to \$70 / prescription (Retail) \$90 <u>Copay</u> / prescription (Mail Order & other retail)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	-----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	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	-----none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$50 <u>Copay</u> + 20% <u>Coinsurance</u>		-----none-----
	<a href="#">Emergency medical transportation</a>	20% <u>Coinsurance</u> <u>Deductible</u> does not apply		Non-PPO non emergent transportation: 40% <u>coinsurance</u>
	<a href="#">Urgent care</a>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	-----none-----
<b>If you have a hospital stay</b>	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%.
<b>If you need mental health, behavioral health, or substance abuse services</b>	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.
<b>If you are pregnant</b>	Office visits	\$20 <u>Copay</u>	40% <u>Coinsurance</u>	-----none-----
	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-----

\* 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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	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.
	<a href="#">Rehabilitation services</a>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	-----none-----
	<a href="#">Habilitation services</a>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to 20 visits per calendar year.
	<a href="#">Skilled nursing care</a>	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.
	<a href="#">Durable medical equipment</a>	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%.
	<a href="#">Hospice services</a>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Pre-certification is required or benefits will be reduced by 50%.
<b>If your child needs dental or eye care</b>	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](#).)

- |                       |  |                            |                        |
|-----------------------|--|----------------------------|------------------------|
| • 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](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 1-800-464-7627.

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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$60
Coinsurance	\$2,435
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,305</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$525
Coinsurance	\$455
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,785</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$0
Coinsurance	\$108
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$858</b>