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.tcsig.com or by calling Delta Health Systems at **1-800-464-7627**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750** person / **$1,500** family for PPO and **$1,500** person / **$3,000** family for Non-PPO. Doesn't apply to co-pays, coinsurance, preventive care, emergency medical transportation, outpatient mental health and outpatient and inpatient substance abuse treatment.	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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Medical – $3,250** person / **$6,500** family for PPO and **$6,500** person / **$13,000** family for Non-PPO. **Prescription – $1,000** person / **$2,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period for your share of the cost of covered services. This limit helps you plan for health care expenses. Medical out-of-pocket limit includes copays, chiropractic and out-patient mental health visits, special charges, and emergency room per occurrence fee. Prescription out-of-pocket limit includes prescription copays.
What is not included in the out–of–pocket limit?	Premiums, deductible, balance-billed charges, and healthcare this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.tcsig.com or call Delta Health Systems at **1-800-464-7627** for a list of PPO 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?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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**.

- **Co-payments** 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 PPO **providers** by charging you lower **deductibles**, **co-payments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	40% coinsurance	——————none——————
	Specialist visit	$20/visit	40% coinsurance	——————none——————
	Other practitioner office visit	$20/visit for acupuncture and 20% coinsurance for massage therapy	40% coinsurance for acupuncture and massage therapy	Acupuncture limited to services by an MD, DO, DC, or licensed acupuncturist for treatment of chronic pain associated with migraine, arthritis, neuritis, sprains or strains. Massage therapy only covered when done by a PT, DC, DO or MD for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion.
	Preventive care/screening/immunization	No charge	40% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need drugs to treat your illness or condition **EnvisionRx Options is the Prescription Drug Provider.** More information about **prescription drug coverage** is available at **www.tcsig.com**.	Generic drugs	$5/prescription (31-day supply retail), $10/prescription (90-day supply retail and mail order)	Not covered	Covers up to a 31-day supply (retail prescription); 90-day supply (retail, and mail order prescription). Mail order requires use of the contracted mail order company or no benefits.
	Preferred Brand drugs	25% coinsurance up to $35/prescription (31-day supply retail), $50/prescription (90-day supply retail and mail order)		
	Non-Preferred Brand drugs	45% coinsurance up to $70/prescription (31-day supply retail), $90/prescription (90-day supply retail and mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery\center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$50/visit, then 20% coinsurance		——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	20% coinsurance	40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-certification is required or benefits will be reduced by 50%.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Pre-certification is required or benefits will be reduced by 50%.

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	50% coinsurance up to $50/visit max	50% coinsurance up to $25/visit max	Pre-certification required or benefits will be reduced by 50%. Limited to 52 visits per calendar year combined with substance use disorder inpatient and outpatient treatment.
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	Pre-certification is required or benefits will be reduced by 50%. Limited to 30 days per calendar year, and 90 days per lifetime combined with chemical dependency.
	Chemical Dependency outpatient services	50% coinsurance up to $50/visit max	50% coinsurance up to $25/visit max	Pre-certification required or benefits will be reduced by 50%. Limited to 52 visits per calendar year combined with substance use disorder inpatient and outpatient treatment.
	Chemical Dependency inpatient services	20% coinsurance	Not covered	Pre-certification is required or benefits will be reduced by 50%. Limited to 30 days per calendar year, and 90 days per lifetime combined with chemical dependency.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	——————none——————
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Pre-certification is required or benefits will be reduced by 50%. Limited to 100 visits per calendar year. Attending physician must certify the person would require confinement as an inpatient in the absence of home health care.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical therapy is only covered to restore physical functioning.
	Habilitation services	Not covered		Not covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-certification is required or benefits will be reduced by 50%. Limited to 100 visits per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	If billed charges are $2,000 or more, pre-certification is required or benefits will be reduced by 50%.
	Hospice service	20% coinsurance	40% coinsurance	Pre-certification is required or benefits will be reduced by 50%.

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.)

- Bariatric surgery
- Dental care
- Development Disorders - Treatment
- Cosmetic Services
- Eye exam
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S
- Routine eye care
- Routine foot care
- Weight loss program

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 (medically necessary only)
- Chiropractic care
- Cosmetic surgery (medically necessary only)
- Home Health Care (100 days per calendar year)
- Skilled Nursing (100 visits per calendar year)

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 1-800-464-7627. 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 1-800-464-7627. You can also contact 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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

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** $5,330
- **Patient pays** $2,210

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	$750
Copays	$10
Coinsurance	$1,300
Limits or exclusions	$150
Total	**$2,210**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,610
- **Patient pays** $790

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	$140
Copays	$570
Coinsurance	$0
Limits or exclusions	$80
Total	**$790**

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.