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, please visit our website at www.benesys.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.benesys.com or call 1-888-208-0250 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For PPO providers: $250 person/$750 family (up to three individuals) For non-PPO providers: $500 person/$1,500 family (up to three individuals) Copayments for medical office visits and charges for dental and vision benefits and prescription drugs do not count towards the overall deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	For PPO providers: $1,250 person/$3,750 family For non-PPO providers: $8,500 person/$25,500 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?	Copayments for office visits, chiropractic, prescription drugs, dental and vision benefits, 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 network provider?	Yes.	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 an out-of-network 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 network provider might use an out-of-network 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

[* For more information about limitations and exceptions, see the plan or policy document at [www.benesys.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
		Network Provider (You will pay the least)	Out-of-Network 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 copayment/visit	$20 copayment/visit	You will not pay more than $10 for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR. Telehealth visits are also a covered benefit.
	Specialist visit	$20 copayment/visit	$40 copayment/visit	You will not pay more than $20 for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Other practitioner office visit	20% coinsurance for chiropractic	40% coinsurance for chiropractic	You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Limited to $1,000 annual maximum. Out-of-network provider coverage limited to UCR.
	Preventive care/screening/ immunization	$10 copayment for routine physical and Well Child visits. 20% coinsurance for Well Woman care. No charge for flu shot under Rx plan	Annual routine physical not covered. $20 copayment for Well Child visits. 40% coinsurance for Well Woman care.	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. Routine and preventive adult immunizations are covered at 80% in-network and 60% out-of-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.ssatpa.com**	Generic drugs	No charge	Not covered	Covers up to 30-day supply (retail subscription); 31-90 day supply (mail order prescription). When available, generic drugs will be substituted for formulary brand drugs, unless a treating physician specifically authorizes the use of a formulary brand drug. Preauthorization is required for Specialty drugs. Certain brand drugs are subject to step therapy which requires you to first try a more cost effective therapeutically equivalent drug.
	Formulary brand drugs	$10 copayment retail $20 copayment mail order	Not covered	
	All other drugs	$40 copayment retail $80 copayment mail order	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	You will have to pay 40% coinsurance for emergency services at a non-PPO facility if (1) you did not have an emergency medical condition; or (2) you receive emergency services for treatment of an emergency medical condition from a non-PPO provider or non-PPO emergency facility and consent to the non-PPO billing rate for certain post-stabilization services. Out-of-network provider coverage limited to UCR.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required for inpatient surgery. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	$10 copayment per visit	$20 copayment per visit	You will not pay more than $10 for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Utilization review required or benefits are not payable. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Substance use disorder outpatient services	$10 copayment per visit	$20 copayment per visit	You will not pay more than $10 for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Utilization review required or benefits are not payable. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Prenatal and postnatal care	20% coinsurance	40% coinsurance	You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required. Maximum 100 visits per calendar year. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Rehabilitation services	20% coinsurance	40% coinsurance	You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care / inpatient hospice	20% coinsurance	40% coinsurance	Preauthorization is required. Maximum benefit of 60 days during any one period of confinement. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Durable medical equipment (rental)	20% coinsurance	40% coinsurance	Rental cost in excess of purchase price is not covered. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Outpatient Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required. Maximum 100 visits per calendar year. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Eye exam	$10 copayment	Covered up to $45 max	Coverage limited to one per year.
	Glasses	$10 copayment per pair; $120 frame allowance	Lenses covered up to $85 depending on type; $47 frame allowance	Coverage limited to one per year for lenses. Coverage limited to one per two years for frames.
	Dental check-up	For Delta PPO enrollees: no charge after $25 deductible For Delta HMO employees: no charge	For Delta PPO enrollees: no charge after $25 deductible For Delta HMO employees: no charge	For Delta PPO enrollees: You will not pay more than $25 for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR. For Delta HMO enrollees: Coverage limited to two per year.

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.)

- Acupuncture
- Cosmetic surgery, except as the result of an injury, for the correction of a congenital defect of a dependent child, or for replacement of diseased tissue surgically removed
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Treatment that is not medically necessary
- Weight loss programs

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

- Bariatric surgery within Medicare national coverage guidelines
- Chantix and other smoking cessation products
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Laser Eye Surgery
- Podiatry Benefits
- Routine eye care (Adult)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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 on how 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: 1-800-432-6636 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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:

[Spanish (Español): Para obtener asistencia en Español, llame al [1-800-432-6636].

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-800-432-6636].

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[1-800-432-6636].

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-800-432-6636].

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** **$250**
- **Specialist coinsurance** **20%**
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,310**

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

- **The plan's overall deductible** **$250**
- **Specialist coinsurance** **20%**
- **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$250
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$970**

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

- **The plan's overall deductible** **$250**
- **Specialist coinsurance** **20%**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$60
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$710**

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