

**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**

**ICSVEBA: Coordination of Benefits (COB)**



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies. secret 17.16 22.6813 >>B T8.56 54 (ee 17.16



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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non	



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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----none

Child - 4/e-f-274(C)6 (h)

Excluded Servi

\* For more information about limitations and exceptions, see the plan or policy document at [www.deltahealthsystems.com](http://www.deltahealthsystems.com)

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

### Managing Joe's type 2 Diabetes

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

### Mia's Simple Fracture

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

„ The <u>plan's</u> overall <u>deductible</u>	\$0
„ <u>Specialist</u> <u>coinsurance</u>	70%
„ Hospital (facility) <u>coinsurance</u>	70%
„ Other <u>coinsurance</u>	70%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)  
Childbirth/Delivery Professional Services  
Childbirth/D