

 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 1-888-212-1231 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p><u>Network Provider</u> \$500 Individual / \$1,000 Family</p> <p><u>Out-of-Network Provider</u> \$1,500 Individual / \$3,000 Family</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive, physician, emergency and urgent care visits, and mental health and substance abuse counseling are covered before you meet your deductible.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. Brand drugs require a \$150.00 deductible be met. Deductible is based on plan year.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Yes. <u>Network Provider</u>: \$2,500 Individual / \$7,500 Family</p> <p><u>Out-of-Network Provider</u>: \$10,000 Individual / \$20,000 Family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billed charges, out-of-network provider deductible and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a participating provider?</p>	<p>Yes. See www.anthem.com/ca or call 1-888-212-1231 for a list of network providers.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>

 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
		EPO Provider (You will pay the least)	Non-EPO 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	\$25 <u>Copay</u>	Not covered	<u>Network provider</u> : <u>Deductible</u> waived
	Specialist visit	\$25 <u>Copay</u>	50% <u>Coinsurance</u>	<u>Network provider</u> : <u>Deductible</u> waived
	Preventive care/screening/immunization	No charge	50% <u>Coinsurance</u>	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Out-of-network hospital</u> : You will pay 50% of the \$600 per day Plan maximum allowed amount and remaining balance.
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.rxipm.com 1-877-860-8846	Generic	\$10 <u>Copay</u> /prescription (retail) \$20 <u>Copay</u> /prescription (mail order)		Limited to 30 days (retail prescription). Limited to 90 day (mail order prescription) Brand Drugs require a \$150 <u>deductible</u> be met. Deductible is based on Plan Year: July – June.
	Formulary	\$25 <u>Copay</u> /prescription (retail) \$50 <u>Copay</u> /prescription (mail order)		
	Brand Non-Formulary	\$40 <u>Copay</u> /prescription retail) \$80 <u>Copay</u> /prescription (mail order)		
Network Specialty Pharmacies	Specialty Drugs	The lesser of \$150 <u>Copay</u> or 20% <u>Coinsurance</u> (retail only)		Contact Walgreens Specialty after one fill from a Retail Pharmacy at 866-202-4014.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Out-of-network hospital</u> : You will pay 50% of the \$600 per day Plan maximum allowed amount and remaining balance.
	Physician/surgeon fees	20% <u>Coinsurance</u>	50% <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
		EPO Provider (You will pay the least)	Non-EPO Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$200 <u>Copay</u>		<u>Copay</u> waived if admitted. <u>Deductible</u> waived.
	Emergency medical transportation	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	-----none-----
	Urgent care	\$25 <u>Copay</u>	50% <u>Coinsurance</u>	<u>Network provider</u> : <u>Deductible</u> waived
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u> and \$250 <u>Copay</u>	20% <u>Coinsurance</u> and \$250 <u>Copay</u> (emergency admission) 50% <u>Coinsurance</u>	<u>Out-of-network</u> hospital: You will pay 50% of the \$600 per day Plan maximum allowed amount and remaining balance when not an emergency admission.
	Physician/surgeon fees	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>Copay</u>	50% <u>Coinsurance</u>	<u>Network provider</u> : <u>Deductible</u> waived <u>Out-of-network</u> : You will pay 50% of the \$600 per day Plan maximum allowed amount and remaining balance.
	Inpatient services	20% <u>Coinsurance</u> and \$250 <u>Copay</u> (per admission)	50% <u>Coinsurance</u>	<u>Out-of-network</u> hospital You will pay 50% of the \$600 per day Plan maximum allowed amount and remaining balance.
If you are pregnant	Office visits	\$25 <u>Copay</u>	50% <u>Coinsurance</u>	-----none-----
	Childbirth/delivery professional services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	-----none-----
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	50% <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
		EPO Provider (You will pay the least)	Non-EPO Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% <u>Coinsurance</u>	Not Covered	Limited to 100 visits per plan year.
	Rehabilitation services	\$25 <u>Copay</u>	50% <u>Coinsurance</u>	Medical treatment plan required.
	Habilitation services	\$25 <u>Copay</u>	50% <u>Coinsurance</u>	<u>Out-of-network</u> hospital: You will pay 50% of the \$600 per day Plan maximum allowed amount.
	Skilled nursing care	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Limited to 100 days per plan year. <u>Out-of-network</u> hospital: You will pay 50% of the \$600 per day Plan maximum allowed amount and remaining balance.
	Durable medical equipment	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Rental up to purchase price. Pre-authorization required.
	Hospice services	\$0 for Respite Care 20% <u>Coinsurance</u> all other Hospice	Not covered	For terminal illness and includes respite, home and general care.
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](#).)

- Cosmetic surgery
- Infertility treatment
- Private-duty nursing
- 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
- Bariatric surgery
- Chiropractic care
- Hearing aids

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 1-800-291-0726, 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 1-800-291-0726. 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 1-800-291-0726.

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-291-0726.

中文: 如果需要中文的帮助, 请拨打这个号码1-800-291-0726.

Dine: Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-291-0726.

-----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](#) \$500
- [Specialist copayment](#) \$25
- 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	\$500
Copayments	\$300
Coinsurance	\$692
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,552

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$25
- 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	\$500
Copayments	\$640
Coinsurance	\$440
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,785

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$25
- 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	\$500
Copayments	\$175
Coinsurance	\$283
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$958