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:
What is the overall deductible?	**Network Provider: $500** Individual/$**1,000** Family **Out- of- Network Provider: $1,500** Individual/**$3,000** Family Network and Out-of-Network Provider deductibles are separate and do not contribute towards each other.	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, physician, emergency and urgent care visits, and mental health and substance abuse counseling are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. Brand drugs require a $150.00 deductible be met. Deductible is based on plan year.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. **Network Provider: $2,500** Individual/**$7,500** Family **Out-of-Network Provider:$10,000** Individual/**$20,000** Family Network and Out-of-Network Provider out-of-pocket limits are separate and do not contribute towards each other.	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?	Premiums, balance-billed charges, out-of-network provider deductible and health care this plan does not 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. See www.anthem.com/ca or call **1-888-212-1231** for a list of network providers.	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.

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	$25 Copay	Not covered	Network provider: Deductible waived
	Specialist visit	$25 Copay	50% Coinsurance	Network provider: Deductible waived
	Preventive care/screening/ immunization	No charge	Not covered	---------- None ----------
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	50% Coinsurance	Out-of-network hospital: You will pay 50% of the $600 per day Plan maximum allowed amount and remaining balance.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Rxipm.com or call 1-877-846-3397.	Generic drugs	$10 Copay/prescription (retail) $20 Copay/prescription (mail order)		Limited to 30 days (retail prescription). Limited to 90 day (mail order prescription) Brand Drugs require a $150 deductible be met. Deductible is based on Plan Year: July – June.
	Preferred brand drugs	$25 Copay/prescription (retail) $50 Copay/prescription (mail order)		
	Non-preferred brand drugs	$40 Copay/prescription retail) $80 Copay/prescription (mail order)		
	Specialty drugs	The lesser of $150 Copay or 20% Coinsurance (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% Coinsurance	50% Coinsurance	Out-of-network hospital: The Plan will pay 50% up to a maximum payment of $600 per day. You will be responsible for the balance.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	---------- None ----------
If you need immediate medical attention	Emergency room care	$200 Copay		Copay waived if admitted Deductible waived
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	---------- None ----------
	Urgent care	$25 Copay	50% Coinsurance	Network provider: Deductible waived

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 and $250 Copay	20% Coinsurance and $250 Copay (emergency admission) 50% Coinsurance	Out-of-network hospital: The Plan will pay 50% up to a maximum payment of $600 per day. You will be responsible for the balance.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	---------- None ----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services Counseling – LiveHealth Online providers	$25 Copay $10 Copay	50% Coinsurance Not covered	Network provider: Deductible waived Out-of-network Outpatient services: The Plan will pay 50% up to a maximum payment of $600 per day. You will be responsible for the balance.
	Inpatient services	20% Coinsurance and $250 Copay (per admission)	50% Coinsurance	Out-of-network hospital: The Plan will pay 50% up to a maximum payment of $600 per day. You will be responsible for the balance.
If you are pregnant	Office visits	$25 Copay	50% Coinsurance	---------- None ----------
	Childbirth/delivery professional services	20% Coinsurance	50% Coinsurance	---------- None ----------
	Childbirth/delivery facility services	20% Coinsurance	50% Coinsurance	---------- None ----------
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not Covered	Limited to 100 visits per plan year.
	Rehabilitation services	$25 Copay	50% Coinsurance	Medical treatment plan required. Out-of-network hospital: The Plan will pay 50% up to a maximum payment of $600 per day. You will be responsible for the balance.
	Habilitation services	$25 Copay	50% Coinsurance	
	Skilled nursing care	20% Coinsurance	50% Coinsurance	Limited to 100 days per plan year. Out-of-network hospital: The Plan will pay 50% up to a maximum payment of $600 per day. You will be responsible for the balance.
	Durable medical equipment	20% Coinsurance	50% Coinsurance	Rental up to purchase price. Pre-authorization required.

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)	
	Hospice services	$0 for Respite Care 20% Coinsurance 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 ----------

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
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Transgender / Gender Dysphoria
- Weight loss programs

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

- Acupuncture
- Bariatric surgery (when medically necessary)
- Chiropractic care
- Hearing aids
- Morbid Obesity
- Private duty nursing
- TMJ

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 [insert State, 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

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:

Español: Para obtener asistencia en Español, llame al 1-800-422-6099.
Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-422-6099.

中文: 如果需要中文的帮助，请拨打这个号码1-800-422-6099.

Dine: Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-422-6099.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.deltahealthsystems.com

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$408
Copayments	$0
Coinsurance	$1,092
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$1,175
Coinsurance	$25
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,405**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$275
Coinsurance	$118
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$893**

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