

 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 1-866-691-2443 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network <u>Provider</u>: \$5,000 Individual / \$10,000 Family Non-Network <u>Provider</u>: \$15,000 Individual / \$30,000 Family Covered expenses applied to your in-network deductible do not count toward your non-network deductible and vice versa.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. <u>Preventive</u> care services with <u>In-Network Providers</u> , emergency room visits, and prescription drugs are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan ?	In-Network <u>Provider</u>: \$6,350 Individual / \$12,700 Family Non-Network <u>Provider</u>: \$25,000 Individual / \$50,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit ?	<u>Premiums</u> , <u>balance-billed</u> charges, penalties for failure to obtain preauthorization for services, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a participating provider ?	Yes. See www.anthem.com/ca or call at 1-866-691-2443 for a list of preferred <u>providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use a Non-Network <u>provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your In-network <u>provider</u> might use a Non-network <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		In-Network Provider (You will pay the least)	Non-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	30% coinsurance	50% coinsurance	-----none-----
	Specialist visit	30% coinsurance	50% coinsurance	-----none-----
	Preventive care/screening/immunization	No charge Deductible does not apply	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	When lab and imaging services are provided at an outpatient lab, x-ray, or imaging facility.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Rxhelp@rxbenefits.com 800-334-8134	Generic	\$5 copay / prescription (Retail and Mail Order)		Retail: 30-day supply Mail Order: 90-day supply
	Brand Formulary	\$25 copay / prescription (Retail and Mail Order)		
	Non-Formulary	\$55 copay / prescription (Retail and Mail Order)		
	Specialty drugs	20% coinsurance / prescription (Retail and Mail Order)		Pre-authorization is required. Specialty drugs are limited to a \$1,000 out-of-pocket maximum. Specialty drug out-of-pocket maximum is not separate from overall out-of-pocket maximum. Contact Accredo for your specialty drug needs at 800-803-2523 or online at www.accredo.com
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Non-Network provider : Limited to \$600 maximum paid per day. Potentially cosmetic or investigative services require pre-authorization.

* 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
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Potentially cosmetic or investigative services require pre-authorization.
If you need immediate medical attention	Emergency room care	\$100 copay / visit and 30% coinsurance Deductible does not apply		Copay is waived if admitted.
	Emergency medical transportation	30% coinsurance Deductible does not apply	50% coinsurance Deductible does not apply	Air ambulance transport from Reach Air Medical is covered at 100% and limited to a maximum benefit of \$12,000 per trip. Air ambulance from other air ambulance providers is limited to a maximum benefit of \$19,000 per trip.
	Urgent care	30% coinsurance	No covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Pre-authorization is required. Non-Network provider : Limited to \$600 maximum paid per day.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Benefits for Mental/Behavioral Health and Substance use disorders are covered through a separate plan with The Holman Group . Call 1-800-321-2843 or www.holmangroup.com
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Cost sharing does not apply to preventive services . Network coinsurance applies for visits not included in physician's global rate.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	-----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
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-authorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay. Non-Network <u>provider</u> : Limited to \$600 maximum paid per day.
If you need help recovering or have other special health needs	Home health care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-authorization is required.
	Rehabilitation services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	The services must be specifically prescribed by a physician as to type and duration and must be for improvement of bodily function.
	Habilitation services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	The services must be specifically prescribed by a physician as to type and duration and must be for improvement of bodily function.
	Skilled nursing care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-authorization is required. Limited to 90 days per confinement.
	Durable medical equipment	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-authorization on purchases in excess of \$2,000 billed per date of service.
	Hospice services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-authorization is required. Terminal prognosis of life-expectancy is six months or less.
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 | • Non-emergency care when traveling outside the U.S. | • Routine foot care (limited) |
| • Dental care (Adult) | • Long term care | • Routine eye care (Adult) | • 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 (limited) | • Chiropractic care | • Hearing aids (limited) | • Private duty nurse |
|---------------|-------------------------------|---------------------|--------------------------|----------------------|

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 1-866-691-2443, 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 1-800-556-7830. 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 1-866-691-2443.

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-691-2443.

中文: 如果需要中文的帮助, 请拨打这个号码1-866-691-2443.

Dine: Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne! 1-866-691-2443.

-----*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](#) \$5000
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$20
Coinsurance	\$1,082
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,162

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

- The [plan's](#) overall [deductible](#) \$5000
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$897
Copayments	\$645
Coinsurance	\$338
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,936

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

- The [plan's](#) overall [deductible](#) \$5000
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$914
Copayments	\$100
Coinsurance	\$407
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,421