
 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](http://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](http://www.deltahealthsystems.com) or call 1-866-691-2443 to request a copy.


Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>In-Network <u>Provider</u>:</b> \$650 Individual / \$1,950 Family  <b>Non-Network <u>Provider</u>:</b> \$1,500 Individual / \$4,500 Family            Covered expenses applied to your in-network deductible do not count toward your non-network deductible and vice versa.</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">Preventive</a> care services, outpatient diagnostic testing and imaging with <a href="#">In-Network <u>Providers</u></a>; emergency room visits, urgent care; and prescription drugs are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>In-Network <u>Provider</u>:</b> \$3,000 Individual / \$9,000 Family  <b>Non-Network <u>Provider</u>:</b> \$9,000 Individual / \$27,000 Family</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><a href="#">Premiums</a>, <a href="#">balance-billed</a> charges, penalties for failure to obtain preauthorization services, expenses which exceed UCR and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">participating provider</a>?</p>	<p>Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call at 1-866-691-2443 for a list of preferred <a href="#">providers</a>.</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. You will pay the most if you use a Non-Network <a href="#">provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware, your In-network <a href="#">provider</a> might use a Non-network <a href="#">provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	50% <a href="#">coinsurance</a>	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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.Rxhelp@rxbenefits.com">www.Rxhelp@rxbenefits.com</a> 800-334-8134	Generic	\$5 <a href="#">copay</a> / prescription (Retail and Mail Order)		Retail: 30-day supply  Mail Order: 90-day supply
	Brand Formulary	\$25 <a href="#">copay</a> / prescription (Retail and Mail Order)		
	Non-Formulary	\$55 <a href="#">copay</a> / prescription (Retail and Mail Order)		
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> / 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 the overall out-of-pocket maximum. Contact Accredo for your specialty drug needs at 800-803-2523 or online at <a href="http://www.accredo.com">www.accredo.com</a>

\* For more information about limitations and exceptions, see the plan or policy document at [www.deltahealthsystems.com](http://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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Potentially cosmetic or investigative services require pre-authorization.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Potentially cosmetic or investigative services require pre-authorization.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply		Copay is waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	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.
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply		-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <a href="#">copay</a> / admission and 20% <a href="#">coinsurance</a>	\$250 <a href="#">copay</a> / admission and 50% <a href="#">coinsurance</a>	Pre-authorization is required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Out-of-network <a href="#">providers</a> rendering services at an in-network facility will be paid as an in-network <a href="#">provider</a> .
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 <b>The Holman Group</b> . Call 1-800-321-2843 or <a href="http://www.holmangroup.com">www.holmangroup.com</a>
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	\$10 <a href="#">copay</a> / PCP visit \$20 <a href="#">copay</a> / Specialist visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to <a href="#">preventive services</a> .  Network <a href="#">copay</a> applies for visits not included in physician's global rate.

\* For more information about limitations and exceptions, see the plan or policy document at [www.deltahealthsystems.com](http://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 professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Childbirth/delivery facility services	\$250 <u>copay</u> / admission and 20% <u>coinsurance</u>	\$250 <u>copay</u> / admission and 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.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-authorization is required.
	<a href="#">Rehabilitation services</a>	\$10 <u>copay</u> / visit <u>Deductible</u> does not apply	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.
	<a href="#">Habilitation services</a>	\$10 <u>copay</u> / visit <u>Deductible</u> does not apply	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.
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	\$500 <u>copay</u> / admission and 50% <u>coinsurance</u>	Pre-authorization required. Limited to 90 days per confinement.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u> <u>Deductible</u> does not apply	50% <u>coinsurance</u>	Pre-authorization on purchases in excess of \$2,000 billed per date of service.  <u>Deductible</u> applies to prosthetics, functional orthotics, supplies and surgical dressings.  <u>In-network providers</u> : The benefit is limited to a maximum out-of-pocket of \$500.

\* For more information about limitations and exceptions, see the plan or policy document at [www.deltahealthsystems.com](http://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)	
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization 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-----

#### 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 (limited)
- 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](http://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](http://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](http://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

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

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](#) \$650
- [Specialist copay](#) \$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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$650
Copayments	\$290
Coinsurance	\$1,792
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,792</b>

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

- The [plan's](#) overall [deductible](#) \$650
- [Specialist copay](#) \$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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$484
Copayments	\$765
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,304</b>

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

- The [plan's](#) overall [deductible](#) \$650
- [Specialist copay](#) \$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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$650
Copayments	\$320
Coinsurance	\$158
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,128</b>