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 1-800-291-0726 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Provider: **$500** individual / **$1,500** family Non-Network Provider: **$1,500** individual / **$3,000** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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 care performed by in-network providers, and outpatient prescription drugs 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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Provider: **$5,000** individual / **$10,000** family Outpatient drugs: **$1,600** individual / **$3,200** family	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, and health care this plan doesn't cover, outpatient retail/mail order drug expenses (which have a separate out-of-pocket), and out-of-network deductibles, copayments and coinsurance except an emergency room visit in cases of an emergency.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a participating provider?	Yes. See www.anthem.com/ca or call 1-800-274-7767 for a list of participating in-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
		Preferred Provider (You will pay the least)	Non-Preferred 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	20% coinsurance	50% coinsurance	----------none----------
	Specialist visit			
	Preventive care/screening/ immunization	No charge Deductible does not apply	50% coinsurance	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. Plan covers preventive services and supplies required by the Health Reform law. Details at: www.healthcare.gov/what-are-my-preventive-care-benefits/.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)			

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: Preferred Provider (You will pay the least)	What You Will Pay: Non-Preferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com 888-895-2557	Generic drugs	Retail: $10 copayment / prescription Mail order: $20 copayment / prescription Deductible does not apply	Not covered	Retail: Up to 30-day supply Mail order: Up to 90-day supply • No charge for FDA-approved generic contraceptives. • You pay the lesser of the copayment or the drug cost. • Some prescriptions are subject to pre-authorization to avoid non-payment. • Certain over-the-counter (OTC) drugs are payable at no charge with a prescription, in compliance with Health Reform. • Mail Order is required for maintenance medications after the first fill at a retail pharmacy.
	Preferred brand drugs	Retail: $35 copayment / prescription Mail order: $70 copayment / prescription Deductible does not apply	Not covered	
	Non-preferred brand drugs	Retail and Mail order: 50% coinsurance Deductible does not apply	Not covered	
	Specialty Drugs	Up to a 30-day supply, you pay the same amount as listed under retail pharmacy in the rows above. Deductible does not apply	Not covered	Contact Caremark for pre-authorization to avoid non-payment at 1-866-387-2573.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Pre-authorization is required to avoid non-payment of expenses.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance		Coinsurance increases to 50% if ER was used in a non-emergency situation. Physician/provider's professional fees may be billed separately.

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
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	Emergency medical transportation	20% coinsurance	50% coinsurance	
	Urgent care	20% coinsurance	50% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$75 copayment / admission + 20% coinsurance	$200 copayment / admission + 50% coinsurance	Pre-authorization of elective hospital admission is required to avoid non-payment of expenses. Private room is covered only if medically necessary or the hospital only has private rooms.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Plan covers up to six EAP visits (three per six month period at no charge) through Integrated Behavioral Health at (800) 395-1616.
	Inpatient services	$75 copayment / admission + 20% coinsurance	$200 copayment / admission + 50% coinsurance	Pre-authorization of elective hospital admission is required to avoid non-payment of expenses.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	• Cost sharing does not apply for preventive services • Depending on the type of services, a copayment, coinsurance or deductible may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). • Prenatal care (other than ACA-required preventive screening is **not covered** for dependent children. • Pre-authorization is required to avoid non-payment of expenses only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$75 copayment / admission + 20% coinsurance	$200 copayment / admission + 50% coinsurance	
If you need help recovering or have other	Home health care	20% coinsurance	Not covered	Pre-authorization is required to avoid non-payment of expenses.

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
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
special health needs	Rehabilitation services	20% coinsurance	50% coinsurance	Pre-authorization of outpatient physical, occupational and speech therapy is required to avoid non-payment of expenses.
	Habilitation services	20% coinsurance	50% coinsurance	Covered for speech therapy. Pre-authorization of speech therapy is required to avoid non-payment of expenses.
	Skilled nursing care	$75 copayment / admission + 20% coinsurance	$200 copayment / admission + 50% coinsurance	Payable only if transferred directly from a covered inpatient stay.
	Durable medical equipment	20% coinsurance	50% coinsurance	No charge from in-network providers for breastfeeding pump & supplies needed to operate the pump.
	Hospice services	20% coinsurance	Not covered	Pre-authorization of hospice is required to avoid non-payment of expenses.
If your child needs dental or eye care	Children's eye exam	Your cost depends on the separate vision plan you select.	Not covered	If you elect vision coverage, it will be available under a separate vision plan.
	Children's glasses	Your cost depends on the separate vision plan you select.	Not covered	If you elect vision coverage, it will be available under a separate vision plan.
	Children's dental check-up	Your cost depends on the separate vision plan you select.	Not covered	If you elect vision coverage, it will be available under a separate vision plan.

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)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 (when necessary due to life-threatening conditions resulting from morbid obesity)
- Chiropractic care
- Infertility treatment (includes physician services, diagnostic tests, medication, surgery, and gamete intra-fallopian transfer)
- Routine foot care (payable when treating diabetic or peripheral vascular insufficiency affecting the feet)

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 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 1-888-212-1231. 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, kwiijigo 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 *coinsurance*	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)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayment	$108
Coinsurance	$2,020
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,688**

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 *coinsurance*	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)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayment	$1080
Coinsurance	$237
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,,872**

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

The plan's overall deductible	$500
Specialist *coinsurance*	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)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayment	$0
Coinsurance	$282
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$782**

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