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 Provider: $1,500** Individual / **$4,500** Family **Non-Network Provider: $3,000** Individual / **$9,000** 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 providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. When seeing an In-Network Provider, preventive care services, physician and emergency room visits, rehabilitation and habilitation therapy; urgent care, and 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.
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: $6,600** Individual / **$13,200** Family **Non-Network Provider: $10,000** Individual / **$30,000** 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, penalties for failure to obtain preauthorization for services, and health care this plan doesn't 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 participating provider?	Yes. See www.anthem.com/ca or call at **1-866-691-2443** for a list of preferred 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 a Non-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 In-network provider might use a Non-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
		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	$35 copay / visit Deductible does not apply	50% coinsurance	----------none----------
	Specialist visit	$70 copay / visit Deductible does not apply	50% coinsurance	----------none----------
	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% 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 the overall out-of-pocket maximum. Contact Accredo for your specialty drug needs at 800-803-2523 or online at www.accredo.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% coinsurance	50% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Out-of-network providers rendering services at an in-network facility will be paid as an in-network provider.
If you need immediate medical attention	Emergency room care	$250 copay / visit Deductible does not apply		Copay is waived if admitted.
	Emergency medical transportation	20% coinsurance		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 copay / visit Deductible does not apply	$30 copay / visit Deductible does not apply	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay and 20% coinsurance	$250 copay and 50% coinsurance	Pre-authorization is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Out-of-network providers rendering services at an in-network facility will be paid as an in-network provider.
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	$35 copay / PCP visit $70 copay / Specialist visit	50% coinsurance	Cost sharing does not apply to preventive services. Network copay applies for visits not

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)	
				included in physician's global rate.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	----------none----------
	Childbirth/delivery facility services	$250 copay / admission and 20% coinsurance	$250 copay / admission and 50% coinsurance	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	Home health care	20% coinsurance	50% coinsurance	Pre-authorization is required.
	Rehabilitation services	$15 copay Deductible does not apply	50% coinsurance	----------none----------
	Habilitation services	$15 copay Deductible does not apply	50% coinsurance	----------none----------
	Skilled nursing care	20% coinsurance	$500 copay / admission and 50% coinsurance	Pre-authorization required. Limited to 90 days per confinement.
	Durable medical equipment	20% coinsurance Deductible does not apply	50% coinsurance	Pre-authorization on purchases in excess of $2,000 billed per date of service. Deductible applies to prosthetics, functional orthotics, supplies and surgical dressings. In-network providers: The benefit is limited to a maximum out-of-pocket of $500.
	Hospice services	20% coinsurance	50% coinsurance	Pre-authorization required. Terminal prognosis of life-expectancy is six months or less.

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 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	• 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, kwiijigo 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	$1500
Specialist copayment	$70
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	$1,500
Copayments	$340
Coinsurance	$367
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,267**

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

The plan's overall deductible	$1500
Specialist copayment	$70
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	$1,500
Copayments	$725
Coinsurance	$356
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,636**

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

The plan's overall deductible	$1500
Specialist copayment	$70
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	$1,379
Copayments	$185
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,572**

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