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 1-800-433-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network Provider: $5,000** Individual No coverage for Non-Network providers. An individual within a family shall not have a deductible that is more than the individual deductible limit. **To satisfy the family deductible, two family members must each meet their individual deductible.	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. Preventive care services, Network physician 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**PPO Provider: $6,850** Individual / **$13,700** Family No coverage for Non-Network providers. For family coverage, an individual within a family shall not have a maximum out-of-pocket limit that is greater than the maximum out-of-pocket limit for an individual.	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. Out-of-pocket limit is $2,000,000/person for non-essential benefits. Unlimited for essential benefits.	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 Delta Health Systems at **1-800-433-2566** 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 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 PPO 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
		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	$60 copay / visit Deductible does not apply	Not covered	Copay applies to visit charge only. All other services done in the office at the time of the visit pay under services rendered.
	Specialist visit			
	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	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Applies to services over $500 per visit.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.rxipm 877-860-8846	Generic (on Basic Formulary)	$10 copay / prescription (retail) $20 (mail order)		Retail: 34-day supply Mail Order: 90-day supply Step therapy and Pre-authorization requirements may apply for certain drug categories.
	Preferred Brand (on Basic Formulary)	$45 copay / prescription (retail) $90 / prescription (mail order)		
	Non-Preferred Brand	$80 copay / prescription (retail) $160 /prescription (mail order)		
	Specialty Drugs	$250 copay / prescription (retail)		Mandatory generic is required. If you or your prescriber choose a brand drug with a generic equivalent, the brand cost of the drug is considered a non-covered expense. Only the generic co-pay will count toward the OOP maximum.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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)	30% coinsurance	Not covered	----------none----------
	Physician/surgeon fees	30% coinsurance	Not covered	----------none----------
If you need immediate medical attention	Emergency room care	$300 copay / visit, then 30% coinsurance		Copay is waived if admitted to hospital directly from the emergency room.
	Emergency medical transportation	30% coinsurance		No benefit for Non-Network, non-emergency.
	Urgent care	30% coinsurance	Not covered	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Services must be pre-authorized in order to avoid a 50% benefit reduction.
	Physician/surgeon fees	30% coinsurance	Not covered	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60 copay / visit Deductible does not apply	Not covered	----------none----------
	Inpatient services	30% coinsurance	Not covered	Services must be pre-authorized in order to avoid a 50% benefit reduction.
If you are pregnant	Office visits	No charge. ($60 copay / visit for non-pregnancy related visits.) Deductible does not apply	Not covered	Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	30% coinsurance	Not covered	Services must be pre-authorized for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid a 50% benefit reduction.
	Childbirth/delivery facility services	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Services must be pre-authorized in order to avoid a 50% benefit reduction.
	Rehabilitation services	30% coinsurance	Not covered	Prescription required for physical therapy from a physician to include the duration and frequency of treatment.
	Habilitation services	30% coinsurance	Not covered	Prescription required for physical therapy from a physician to include the duration and frequency of treatment.
	Skilled nursing care	30% coinsurance	Not covered	Services must be pre-authorized in order to avoid a 50% benefit reduction. Limited to 100 days per calendar year.
	Durable medical equipment	30% coinsurance	Not covered	----------none----------
	Hospice services	30% coinsurance	Not covered	Limited to terminal prognosis when 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nurse
- Routine eye care (Adult)
- Routine foot care (limited)

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

- Bariatric surgery (medically necessary)
- Chiropractic care ($500 per calendar year)
- Infertility treatment (except artificial impregnation)
- Weight loss programs (services must be pre-certified by Sante)

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 1-800-433-2566, 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 1-800-433-2566. 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 1-800-433-2566.

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-433-2566.

中文: 如果需要中文的帮助，请拨打这个号码1-800-433-2566.

Dine: Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-433-2566.

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 copayment	$60
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:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,850
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,910**

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 copayment	$60
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:

Cost Sharing	
Deductibles	$4,599
Copayments	$420
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$5,074**

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

The plan's overall deductible	$5000
Specialist copayment	$60
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:

Cost Sharing	
Deductibles	$1,632
Copayments	$120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,752**

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