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 1-800-556-7265 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network Provider: $250** Individual / **$750** Family **Out-of-Network Provider: $500** Individual / **$1,500** Family	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, acupuncture, chiropractic, physician and emergency room visits, mental health and substance abuse counseling, rehabilitation and habilitation therapy; and urgent care 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: $2,500** Individual / **$5,000** Family **Non-PPO Provider: $3,500** Individual / **$7,000** Family **Prescription**: $4,100 Individual / $8,200 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, 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 Delta Health Systems at **1-800-556-7265** 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-PPO 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-PPO 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)	Out-of-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	$25 copay / visit and 5% coinsurance for other outpatient services Deductible does not apply	$25 copay / visit and 30% coinsurance for other outpatient services Deductible does not apply	----------none----------
	Specialist visit			
	Preventive care/screening/ immunization	No charge Deductible does not apply	30% coinsurance Deductible does not apply	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. Limited to one exam per calendar year for ages 18 and older.
If you have a test	Diagnostic test (x-ray, blood work)	5% coinsurance	30% coinsurance	----------none----------
	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.optumrx.com 800-626-0072	Generic	$5 copay / prescription (Retail) and $10 (Mail Order)		Retail: 30-day supply Mail Order: 90-day supply
	Brand Formulary	$20 copay / prescription (Retail) $40 (Mail Order)		
	Brand Non-Formulary	$35 copay / prescription (Retail) $70 (Mail Order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	30% coinsurance	----------none----------
	Physician/surgeon fees	5% coinsurance	30% coinsurance	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay / visit and 5% coinsurance Deductible does not apply		Copay is waived if admitted.
	Emergency medical transportation	5% coinsurance		----------none----------
	Urgent care	$25 copay / visit and 5% coinsurance Deductible does not apply		Services rendered in a hospital will be paid under the emergency room facility benefit.
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1 – No charge Tier 2 – 10% coinsurance Tier 3 – 20% coinsurance	20% coinsurance	----------none----------
	Physician/surgeon fees	5% coinsurance	30% coinsurance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay / visit and 5% coinsurance Deductible does not apply	$25 copay / visit and 30% coinsurance Deductible does not apply	----------none----------
	Inpatient services	Tier 1 – No charge Tier 2 – 10% coinsurance Tier 3 – 20% coinsurance	20% coinsurance	----------none----------
If you are pregnant	Office visits	$25 copay / visit and 5% coinsurance for other outpatient services Deductible does not apply	$25 copay / visit and 30% coinsurance for other outpatient services Deductible does not apply	Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	5% coinsurance	30% coinsurance	----------none----------
	Childbirth/delivery facility services	5% coinsurance	30% coinsurance	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	5% coinsurance	30% coinsurance	Preauthorization required
	Rehabilitation services	5% coinsurance Deductible does not apply	30% coinsurance Deductible does not apply	Physical therapy must be prescribed by an MD or DO. Speech therapy covered when medically necessary.
	Habilitation services	5% coinsurance Deductible does not apply	30% coinsurance Deductible dos not apply	Physical therapy must be prescribed by an MD or DO. Speech therapy covered when medically necessary.
	Skilled nursing care	5% coinsurance	30% coinsurance	Preauthorization required
	Durable medical equipment	5% coinsurance		----------none----------
	Hospice services	5% coinsurance	30% coinsurance	Preauthorization required
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	• Hearing aids	• Long term care	• Private duty nurse	• Routine foot care (limited)
• Dental care (Adult)	• Infertility treatment	• Non-emergency care when traveling outside the U.S.	• 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	• Chiropractic care

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 1-800-556-7265, 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 1-800-556-7265.
Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-556-7265.
中文: 如果需要中文的帮助，请拨打这个号码1-800-556-7265.
Dine: Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-556-7265.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.deltahealthsystems.com

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	$250
Specialist *copayment*	$25
Hospital (facility) *coinsurance*	0%
Other *coinsurance*	5%

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	$250
Copayments	$20
Coinsurance	$170
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$500**

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

The plan's overall deductible	$250
Specialist *copayment*	$25
Hospital (facility) *coinsurance*	0%
Other *coinsurance*	5%

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	$250
Copayments	$603
Coinsurance	$105
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,013**

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

The plan's overall deductible	$250
Specialist *copayment*	$25
Hospital (facility) *coinsurance*	0%
Other *coinsurance*	5%

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	$250
Copayments	$150
Coinsurance	$181
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$581**

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