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, call 1-800-417-8923. 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 1-800-417-8923 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 (No deductible)	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Covered services are not subject to a deductible.	This plan covers services without any applicable deductible. 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?	For medical PPO network providers: $1,000 individual / $2,000 family; for medical non-PPO provider: there is no out-of-pocket limit. For prescription copayments: $8,100 individual / $16,200 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?	Certain coinsurance, copayments, premiums, balance-billed charges, non-covered services, and penalties for not obtaining required preauthorization.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Amounts in excess of Reasonable and Allowed & Usual, Customary, and Reasonable (UCR) for out-of-network services.
Will you pay less if you use a network provider?	Yes. See https://www.anthem.com/ca/find-care/ or call 1-800-417-8923 for list of Anthem Blue Cross network providers. For substance abuse treatment, TARP has its own provider list. Call TARP at 800-522-8277 for 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 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
		Network Provider (You will pay the least)	Non-PPO 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 copay/office visit	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Includes Family Practice, General Practice, Internal Medicine, OB/GYN, and Pediatric office visits. Treatment must be medically necessary.
	Specialist visit	20% coinsurance	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Treatment must be medically necessary.
	Preventive care/screening/ immunization	No charge	Not covered. You pay 100% of charges.	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. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Treatment must be medically necessary.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Treatment must be medically necessary.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	$10 copay/Rx retail $20 copay/Rx mail order	You pay 100% of cost at pharmacy; reimbursable to in-network rate.	Up to 30-day supply retail or 100-day supply mail order. Generics required. Medical necessity & step therapies apply.
	Preferred brand drugs	$20 copay/Rx retail $40 copay/Rx mail order	You pay 100% of cost at pharmacy; reimbursable to in-network rate.	Up to 30-day supply retail or 100-day supply mail order. Generics required. Medical necessity & step therapies apply.
	Non-preferred brand drugs	$40 copay/Rx retail $80 copay/Rx mail order	You pay 100% of cost at pharmacy; reimbursable to in-network rate.	Up to 30-day supply retail or 100-day supply mail order. Generics required. Medical necessity & step therapies apply.
	Specialty drugs	$50 copay/Rx retail $100 copay/Rx mail order	You pay 100% of cost at pharmacy; reimbursable to in-network rate.	Up to a 30-day supply retail or mail order. Specialty drugs must be obtained through Optum Specialty Pharmacy. Call Optum Specialty Pharmacy at 1-855-427-4682 for information regarding any supply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
				limitations, copays, and available programs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Hospital Outpatient: 50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges. Surgery Center: Not Covered. You pay 100% of charges.	Must be medically necessary.
	Physician/surgeon fees	20% coinsurance	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Must be medically necessary.
If you need immediate medical attention	Emergency room care	$100 copay/visit for facility; 20% coinsurance for professional services.	$100 copay/visit for facility; 20% coinsurance of Reasonable and Allowed charges for professional services.	Copay waived if admitted. Must involve a sudden onset of severe medical symptoms requiring immediate medical treatment or that could be considered life-threatening. Must be medically necessary.
	Emergency medical transportation	20% coinsurance	20% coinsurance of Reasonable and Allowed.	Must be medically necessary.
	Urgent care	20% coinsurance	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Must be medically necessary.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges (when PPO Hospital is available).	Bariatric surgery maximum allowed of $25,000, payable at 80%, is inclusive of facility and professional charges at a Blue Cross Distinction Center. Patient responsibility of 20% does not apply to the out-of-pocket maximum. Organ transplants limited to one transplant per organ. Benefit reduced by 20% if not preauthorized. Must be medically necessary.
	Physician/surgeon fees	20% coinsurance	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Must be medically necessary.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Must be medically necessary.
	Inpatient services	No charge	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Must be medically necessary. Mental Health Services: Benefit reduced by 20% if not preauthorized by Anthem Substance Abuse Services: Benefit reduced by 20% if not preauthorized by TARP.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Cost sharing does not apply for preventive services. Must be medically necessary. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Services must be preauthorized for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay or benefit reduced by 20%. Must be medically necessary. Benefit applies to the employee covered by the Plan or the covered employee's spouse or domestic partner.
	Childbirth/delivery facility services	No charge	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Benefit reduced by 20% if not preauthorized. Must be medically necessary.
	Rehabilitation services	20% coinsurance	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Chiropractic services are limited to $1,500 per year. Physical therapists, speech therapists, occupational therapists are limited to 24 visits each calendar year. Must be medically necessary.
	Habilitation services	20% coinsurance	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
			charges.	
	Skilled nursing care	No charge	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Maximum 120 days per disability period. Benefit reduced by 20% if not preauthorized. Must be medically necessary.
	Durable medical equipment	20% coinsurance No charge for CPAP machines	50% coinsurance of Reasonable and Allowed, and 100% of non-allowed charges.	Benefit reduced by 20% if charges exceeding $2,000 are not preauthorized. Must be medically necessary.
	Hospice services	20% coinsurance	20% coinsurance of Reasonable and Allowed	Benefit reduced by 20% if not preauthorized.
If your child needs dental or eye care	Children's eye exam	VSP: $10 Copay	VSP: Charges over $50	VSP: One exam every 12 months
	Children's glasses	VSP: Charges exceeding$150 for frames	VSP: Charges over $70	VSP: One frame and lenses every 24 months.
	Children's dental check-up	No charge	No charge up to Usual, Customary, and Reasonable (UCR).	One exam allowed every 6 months. If you select a DHMO Plan, there is no benefit if you go to an out-of-network provider.

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.)

- Abortion (Elective)
- Acupuncture
- Charges for surrogacy pregnancy
- Cosmetic surgery
- Experimental treatments
- Infertility Treatment
- Long-term care (Custodial)
- Non-emergency care traveling outside the U.S
- Pregnancy of dependent daughters
- Private-duty nursing
- Routine foot care
- TMJ (with certain exceptions)
- Treatment for sexual dysfunction
- Weight loss programs (Except Bariatric Surgery)

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

- Bariatric Surgery
- Biometric Screening (Annual)
- Chiropractic services
- Dental Care (Adult)
- Hearing aids
- Routine eye care (Adult)
- Telemedicine

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

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 are the plan at 1-800-417-8923, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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 1-800-417-8923. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-417-8923.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-417-8923.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-417-8923.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-417-8923.

*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	**$0**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**0%**
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

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

The plan's overall deductible	**$0**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs *(including glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

The plan's overall deductible	**$0**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**0%**
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$500
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$600**

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

THIS PAGE INTENTIONALLY LEFT BLANK