



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 <u>deductible</u> ?	\$0 (No <u>deductible</u>)	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Covered services are not subject to a <u>deductible</u> .	This <u>plan</u> covers services without any applicable <u>deductible</u> , but a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You do not have to meet a <u>deductible</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For medical PPO <u>network providers</u> : \$1,000 individual / \$2,000 family; for medical <u>non-PPO provider</u> : there is no <u>out-of-pocket limit</u> . For prescription <u>copayments</u> : \$7,150 individual / \$14,300 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Certain <u>coinsurance</u> , <u>copayments</u> , <u>premiums</u> , <u>balance-billed</u> charges, non-covered services, and penalties for not obtaining required <u>preauthorization</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . Amounts in excess of Reasonable & Allowed for out-of-network services.
Will you pay less if you use a <u>network provider</u> ?	Yes. To locate an Anthem Blue Cross <u>provider</u> , go to https://www.anthem.com/ca/find-care/ For substance abuse treatment, TARP has its own provider list. Call TARP at 800-522-8277 for a copy of the list.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use a <u>non-PPO provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your PPO <u>network provider</u> might use a non-PPO <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>Provider</u> (You will pay the least)	<u>Non-PPO Provider</u> (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.WellDyne.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.	Specialty drugs eligible for the Intercept program will be subject to a 40% participant copay . Copay may be waived by enrolling in the Intercept Program. Call US Specialty Care at 1-800-641-

[* 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)	
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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Hospital Outpatient: 50% <u>coinsurance</u> 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% <u>coinsurance</u>	50% <u>coinsurance</u> of Reasonable and Allowed, and 100% of non-allowed charges.	Must be medically necessary.
If you need immediate medical attention	Emergency room care	\$100 <u>copay/visit</u> for facility; 20% <u>coinsurance</u> for professional services.	\$100 <u>copay/visit</u> for facility; 20% <u>coinsurance</u> of Reasonable and Allowed charges, plus 100% of charges over Reasonable and Allowed for professional services.	<u>Copay</u> 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% <u>coinsurance</u>	20% <u>coinsurance</u> of Reasonable and Allowed.	Must be medically necessary.
	Urgent care	20% <u>coinsurance</u>	50% <u>coinsurance</u> 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% <u>coinsurance</u> 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 <u>out-of-pocket maximum</u> . Organ transplants limited to one transplant per organ. Benefit reduced by 20% if not <u>preauthorized</u> . Must be medically necessary.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u> of Reasonable and Allowed, and 100% of non-allowed charges.	Must be medically necessary.

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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% <u>coinsurance</u>	50% <u>coinsurance</u> of Reasonable and Allowed, and 100% of non-allowed charges.	Must be medically necessary.
	Inpatient services	No charge	50% <u>coinsurance</u> of Reasonable and Allowed, and 100% of non-allowed charges.	Must be medically necessary. Mental Health Services: Benefit reduced by 20% if not <u>preauthorized</u> by Anthem Substance Abuse Services: Benefit reduced by 20% if not preauthorized by TARP.
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u> of Reasonable and Allowed, and 100% of non-allowed charges.	<u>Cost sharing</u> does not apply for <u>preventive services</u> . 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% <u>coinsurance</u>	50% <u>coinsurance</u> of Reasonable and Allowed, and 100% of non-allowed charges.	Services must be <u>preauthorized</u> 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.
	Childbirth/delivery facility services	No charge	50% <u>coinsurance</u> of Reasonable and Allowed, and 100% of non-allowed charges.	Benefit applies to the employee covered by the <u>Plan</u> or the covered employee's spouse or domestic partner.
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	50% <u>coinsurance</u> of Reasonable and Allowed, and 100% of non-allowed charges.	Benefit reduced by 20% if not <u>preauthorized</u> . Must be medically necessary.
	Rehabilitation services	20% <u>coinsurance</u>	50% <u>coinsurance</u> 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% <u>coinsurance</u>	50% <u>coinsurance</u> of Reasonable and Allowed, and 100% of non-allowed charges.	
	Skilled nursing care	No charge	50% <u>coinsurance</u> of Reasonable and Allowed, and 100% of non-allowed charges.	Maximum 120 days per disability period. Benefit reduced by 20% if not <u>preauthorized</u> . Must be medically necessary.

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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)	
	Durable medical equipment	20% <u>coinsurance</u> No charge for CPAP machines	50% <u>coinsurance</u> of Reasonable and Allowed, and 100% of non-allowed charges.	Benefit reduced by 20% if charges exceeding \$2,000 are not <u>preauthorized</u> . Must be medically necessary.
	Hospice services	20% <u>coinsurance</u>	20% <u>coinsurance</u> of Reasonable and Allowed	Benefit reduced by 20% if not <u>preauthorized</u> .
If your child needs dental or eye care	Children's eye exam	VSP: \$10 <u>Copay</u>	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 pair frames and lenses, or one set of contact lenses in lieu of frames 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 a <u>provider</u> outside of the <u>network</u> .

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 .)		
<ul style="list-style-type: none"> • Abortion (Elective) • Acupuncture • Charges for surrogacy pregnancy • Cosmetic surgery • Experimental treatments 	<ul style="list-style-type: none"> • Infertility Treatment • Long-term care (Custodial) • Non-emergency care traveling outside the U.S • Pregnancy of dependent daughters • Private-duty nursing 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Bariatric Surgery • Biometric Screening (Annual) • Chiropractic services 	<ul style="list-style-type: none"> • Dental Care (Adult) • Hearing aids 	<ul style="list-style-type: none"> • 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, 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 x 61565m or www.ccio.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 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: contact the plan at 1-800-417-8923. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or <https://www.dol.gov/agencies/ebsa/workers-and-families/additional-protections>.

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, kwijigo holne' 1-800-417-8923.

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](#) \$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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
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](#)
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$620

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$100
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$
The total Mia would pay is	\$600

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.