

 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](http://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](http://www.deltahealthsystems.com) or call the Benefits Help Desk 1-925-287-7280 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	Network: \$500 individual / \$1,000 family Out-of-Network: \$1,000 individual / \$2,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Network preventive care services</a> , outpatient mental health and substance abuse, physician office visits, travel related to bariatric surgery, and vision exams are not subject to the deductible.	This <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Network: \$1,500 individual / \$3,000 family Out-of-Network: \$1,500 individual / \$3,000 family Pharmacy limit: \$2,000 individual / \$4,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , balance-billed charges, pre-authorization penalties, charges in excess of the usual, customary and reasonable, prescriptions and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">participating provider</a> ?	Yes. See <a href="http://www.blueshieldca.com">www.blueshieldca.com</a> or 1-800-219-0030 <a href="#">option 1</a> for a list of Network <a href="#">providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use a Non-Network <a href="#">provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your PPO- <a href="#">provider</a> might use a non- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	Non-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <b>copayment</b> <u>Deductible</u> does not apply	30% <b>coinsurance</b>	The <b>copayment</b> applies to the office visit only. All other services done during the visit are subject to the <b>deductible</b> and <b>coinsurance</b>
	<a href="#">Specialist</a> visit	\$20 <b>copayment</b> <u>Deductible</u> does not apply	30% <b>coinsurance</b>	The <b>copayment</b> applies to the office visit only. All other services done during the visit are subject to the <b>deductible</b> and <b>coinsurance</b>
	<a href="#">Preventive care/screening/immunization</a>	No charge <u>Deductible</u> does not apply	30% <b>coinsurance</b>	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. Not covered for foreign travel/occupational reasons.  Non-Network: Immunizations are not covered.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <b>coinsurance</b>	30% <b>coinsurance</b>	Pre-authorization is required.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> 800-334-8134	Generic	Retail: \$5 <b>copayment</b> Mail order: \$10 <b>copayment</b>	\$5 + 50% AWP/Retail Order	Supply/order: Up to 30 day (retail); 90 day (mail or CVS Pharmacy), except where quantity limits apply. Prior authorization is required for select drugs. If a participant buys a brand name drug that has a generic equivalent, he or she will pay the difference in cost between the brand name and generic drug plus the <b>copayment</b> or <b>coinsurance</b> for generic.
	Formulary Brand	Retail: \$15 <b>copayment</b> Mail order: \$30 <b>copayment</b>	\$15 + 50% AWP/Retail Order	
	Non-Formulary Brand	Retail: \$35 <b>copayment</b> Mail order: \$70 <b>copayment</b>	\$35 + 50% AWP/Retail Order	

\* For more information about limitations and exceptions, see the plan or policy document at [www.deltahealthsystems.com](http://www.deltahealthsystems.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
		Network Provider (You will)	Non-Network Provider (You will pay the most)	
	Specialty Drugs	\$20 <u>copayment</u>	30% <u>coinsurance</u>	Supply/order: Up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. A prior authorization is required for selected drugs. Out-of-network providers may require up-front payment from you.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-authorization is required for certain outpatient procedures.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <u>copayment</u> , then 10% <u>coinsurance</u>		<u>Copayment</u> is waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>		-----none-----
	<a href="#">Urgent care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-authorization is required to avoid a 20% benefit reduction.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copayment</u> <u>Deductible</u> does not apply	30% <u>coinsurance</u>	-----none-----
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-authorization is required to avoid a 20% benefit reduction.
If you are pregnant	Office visits	No charge / prenatal visit 10% postnatal visits \$20 <u>copayment</u> / Non-Pregnancy related visits <u>Deductible</u> does not apply	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to <u>In-Network preventive services</u> .  The <u>copayment</u> applies to the office visit only. All other services done during the visit are subject to the <u>deductible</u> and <u>coinsurance</u>

\* For more information about limitations and exceptions, see the plan or policy document at [www.deltahealthsystems.com](http://www.deltahealthsystems.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
		Network Provider (You will)	Non-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	No charge	Four hours maximum per day and 20 hours maximum per week.
	<a href="#">Rehabilitation services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	<a href="#">Habilitation services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	120 days maximum per calendar year. Prior Authorization is required.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Prior Authorization is required for, but not limited to motorized wheelchairs, insulin infusion pumps, and CPAP machines.
	<a href="#">Hospice services</a>	No charge	No charge	Prior-authorization is required for inpatient services. Five consecutive days of inpatient respite care may be authorized to provide relief for those caring for the member.
If your child needs dental or eye care	Children's eye exam	\$20 <u>copayment</u> <u>Deductible</u> does not apply	30% <u>coinsurance</u>	Not a benefit after age 17.
	Children's glasses	Not covered	Not covered	Refer to vision plan
	Children's dental check-up	Not covered	Not covered	Refer to dental plan

\* For more information about limitations and exceptions, see the plan or policy document at [www.deltahealthsystems.com](http://www.deltahealthsystems.com)

## 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](#).)

- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nurse
- 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
- Cosmetic surgery (covered under certain circumstances)
- Infertility
- Routine eye care
- Routine foot care (when related to a metabolic or peripheral vascular disease)

**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 1-800-422-6099, 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](http://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](http://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 1-800-422-6099. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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:

Español: Para obtener asistencia en Español, llame al 1-800-422-6099.

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-422-6099.

中文: 如果需要中文的帮助, 请拨打这个号码1-800-422-6099.

Dine: Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-422-6099.

-----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 at St. Rose Hospital)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayment	\$10
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,470</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayment	\$600
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,130</b>

**Mia's Simple Fracture**  
(St. Rose Hospital emergency room visit and follow up care with in-network provider)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayment	\$70
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$770</b>