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: $400 Individual / Non-Network: $5,000 Individual An individual within a family shall not have a deductible that is more than the individual deductible limit. **To satisfy the In-Network and Non-Network family deductible, three family members must each meet their individual deductible. In-Network and Non-Network do not cross contribute.	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, 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?	In-Network: $3,000 Individual / Family – Three times the individual out-of-pocket. Non-Network: $10,000 Individual / Family – Three times the individual out-of-pocket (medical) 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. Network Pharmacies: $3,000 Individual / $7,500 (2.5x) Family For the 2020 plan year, the combined Medical and Prescription annual out-of-pocket maximum for covered services received In-Network will not exceed limits of $8,150 per individual or $16,300 for family coverage.	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, expenses which exceed Anthem contracted pricing, 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.blueshieldca.com/networkPPO 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	$30 copay / visit Deductible does not apply	50% coinsurance	Copay applies to the visit charge only. All other services done at the time of the visit pay under services rendered.
	Specialist visit	$60 copay / visit Deductible does not apply		
	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 copay / then,10% coinsurance	$30 copay / then, 50% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	$75 copay / then, 10% coinsurance	$75 copay / then 50% coinsurance	----------none----------
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) and $20 copay (mail Order)		Retail: 34-day supply Mail Order: 90-day supply Step therapy and Pre-authorization requirements may apply for certain drug categories. Mandatory generic is required. If you or your prescriber choose a brand drug
	Preferred Brand (on Basic Formulary)	$45 copay / prescription (retail) $90 copay / prescription (mail order)		
	Non-Preferred Brand	$80 copay / prescription (retail) $160 copay /prescription (mail order)		

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)	
	Specialty Drugs	$250 copay / prescription (retail)		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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgery center: $150 copay / visit Outpatient hospital: $200 copay / visit then, 10% coinsurance		$150 copay applicable for same-day or overnight stay at an ambulatory surgical center.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	$300 copay / visit, then 10% coinsurance		Copay is waived if admitted to hospital directly from the emergency room. 50% coinsurance applies to Non-Network and non-emergency
	Emergency medical transportation	10% coinsurance		50% coinsurance applies to Non-Network and non-emergency
	Urgent care	$50 copay /visit, then 10% coinsurance	$50 copay /visit, then 50% coinsurance	If services are a medical emergency, benefit will pay as indicated under Network provider benefits (subject to usual and customary rules UCR).
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay / admission, then 10% coinsurance	$250 copay / admission, then 50% coinsurance	$250 copay per day up to a maximum of $750 per admission. Services must be pre-authorized in order to avoid a 50% benefit reduction.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	----------none----------

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 mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay / visit Deductible does not apply	50% coinsurance	----------none----------
	Inpatient services	$250 copay / admission, then 10% coinsurance	$250 copay / admission, then 50% coinsurance	$250 copay per day up to a maximum of $750 per admission. Services must be pre-authorized in order to avoid a 50% benefit reduction.
If you are pregnant	Office visits	No charge. (PCP: $30 copay / visit Specialist: $50 copay / visit for non-pregnancy related visits.) Deductible does not apply	50% coinsurance	Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	$250 copay per day up to a maximum of $750 per admission. 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	$250 copay per day, then 10% coinsurance	$250 copay per day, then 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Services must be pre-authorized in order to avoid a 50% benefit reduction. Two visits allowed per day.
	Rehabilitation services	10% coinsurance	50% coinsurance	----------none----------
	Habilitation services	10% coinsurance	50% coinsurance	----------none----------
	Skilled nursing care	10% coinsurance	50% coinsurance	Services must be pre-authorized in order to avoid a 50% benefit reduction. Limited to 100 days per calendar year.
	Durable medical equipment	10% coinsurance	50% coinsurance	----------none----------

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)	
	Hospice services	10% coinsurance	50% coinsurance	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	• Dental care (Adult)	• Long term care	• Private duty nurse	• Routine foot care (limited)
• Cosmetic surgery	• Hearing aids	• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)	

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	$400
Specialist *copayment*	$50
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)*

Total Example Cost	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$593
Coinsurance	$1,217
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,270

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

The plan's overall deductible	$400
Specialist *copayment*	$60
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)*

Total Example Cost	$7,389

In this example, Joe would pay:

Cost Sharing	
Deductibles	$182
Copayments	$1,770
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,007

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

The plan's overall deductible	$400
Specialist *copayment*	$50
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)*

Total Example Cost	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$120
Coinsurance	$163
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$683

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