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 the Benefits Help Desk 1-925-287-7280 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No. Covered services are not subject to a 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?	$1,500 per person / $3,000 two member / $4,500 family Prescription drug: $2,000 per person / $4,000 two members and 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, 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 out-of-pocket limit.
Will you pay less if you use a participating provider?	Yes. See www.blueshieldca.com or 1-800-219-0030 option 1 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 network 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	$20 copayment	Not covered	----------none----------
	Specialist visit	$20 copayment	Not covered	----------none----------
	Preventive care/screening/ immunization	No charge	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. Limited to one visit per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	$100 copayment	Not covered	Network Provider: Includes MUGA and SPECT.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com 800-334-8134	Generic	Retail: $10 copayment Mail order: $20 copayment	Not covered	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 copayment or coinsurance for generic.
	Formulary Brand	Retail: $25 copayment Mail order: $50 copayment	Not covered	
	Non-Formulary Brand	Retail: $35 copayment Mail order: $70 copayment	Not covered	
	Specialty Drugs	20% coinsurance	Not covered	Up to a $100 copayment maximum for each prescription. Prior authorization is required for select drugs. Quantity limits may apply to select drugs. Supply/order: Up to 30 days' supply filled specialty pharmacy.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Pre-authorization is required for certain outpatient procedures to avoid a 20% benefit reduction.
	Physician/surgeon fees	No charge	Not covered	----------none----------
If you need immediate medical attention	Emergency room care	$100 copayment		Copayment is waived if admitted. Non-emergency visits are not covered.
	Emergency medical transportation	$100 copayment		----------none----------
	Urgent care	$20 copayment	Not covered	Copayment is waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Pre-authorization is required.
	Physician/surgeon fees	No charge	Not covered	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment $10 copayment / group session	Not covered	----------none----------
	Inpatient services	20% coinsurance	Not covered	Pre-authorization is required.
If you are pregnant	Office visits	No charge / prenatal and postnatal visits $20 copayment / Non-pregnancy related visits	Not covered	Cost sharing does not apply to In-Network preventive services.
	Childbirth/delivery professional services	No charge	Not covered	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	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	Days 1-30: No charge Days 31-100: $20 copayment /day	Not covered	100 visit maximum per calendar yearLimited to 4 hours per visit and 1 visit per day. Prior Authorization is required.

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)	
	Rehabilitation services	$20 copayment	Not covered	----------none----------
	Habilitation services	$20 copayment	Not covered	----------none----------
	Skilled nursing care	Days 1-10: No charge Days 11-100: $25 copayment /day	Not covered	100 visit maximum per calendar year. Prior Authorization is required.
	Durable medical equipment	No charge	Not covered	Prior Authorization is required for, but not limited to motorized wheelchairs, insulin infusion pumps, and CPAP machines.
	Hospice services	No charge	Not covered	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 copayment	Not covered	----------none----------
	Children's glasses	Not covered	Not covered	Refer to vision plan
	Children's dental check-up	Not covered	Not covered	Refer to dental plan

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)	• Long-term care	• Private duty nurse	• Weight loss programs
• Hearing aids	• Non-emergency care when traveling outside the U.S.	• Routine foot care	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic	• Infertility treatment
• Bariatric surgery	• Cosmetic surgery (covered under certain circumstances)	• Routine eye 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 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. 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 1-800-422-6099. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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, kwiijigo 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	$0
Specialist *copayment*	$20
Hospital (facility) *coinsurance*	20%
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
Copayment	$10
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,470

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 *copayment*	$20
Hospital (facility) *coinsurance*	20%
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

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayment	$300
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$310

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

The plan's overall deductible	$0
Specialist *copayment*	$20
Hospital (facility) *coinsurance*	20%
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
Copayment	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$200

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