



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 <u>deductible</u> ?	\$0	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> ?	No. Covered services are not subject to a deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$1,500 per person / \$3,000 two member / \$4,500 family Prescription drug: \$2,000 per person / \$4,000 two members and 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> ?	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 <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>participating provider</u> ?	Yes. See www.blueshieldca.com or 1-800-219-0030 option 1 for a list of Network <u>providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use a Non- <u>Network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use a non- <u>network 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 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 <u>copayment</u>	Not covered	-----none-----
	<u>Specialist</u> visit	\$20 <u>copayment</u>	Not covered	-----none-----
	<u>Preventive care/screening/immunization</u>	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	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$100 <u>copayment</u>	Not covered	<u>Network Provider</u> : Includes MUGA and SPECT.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com 800-334-8134	Generic	Retail: \$10 <u>copayment</u> Mail order: \$20 <u>copayment</u>	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 <u>copayment</u> or <u>coinsurance</u> for generic.
	Formulary Brand	Retail: \$25 <u>copayment</u> Mail order: \$50 <u>copayment</u>	Not covered	
	Non-Formulary Brand	Retail: \$35 <u>copayment</u> Mail order: \$70 <u>copayment</u>	Not covered	
	Specialty Drugs	20% <u>coinsurance</u>	Not covered	Up to a \$100 <u>copayment</u> 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% <u>coinsurance</u>	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	<u>Emergency room care</u>	\$100 <u>copayment</u>		<u>Copayment</u> is waived if admitted. Non-emergency visits are not covered.
	<u>Emergency medical transportation</u>	\$100 <u>copayment</u>		-----none-----
	<u>Urgent care</u>	\$20 <u>copayment</u>	Not covered	<u>Copayment</u> is waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	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 <u>copayment</u> \$10 <u>copayment</u> / group session	Not covered	-----none-----
	Inpatient services	20% <u>coinsurance</u>	Not covered	Pre-authorization is required.
If you are pregnant	Office visits	No charge / prenatal and postnatal visits \$20 <u>copayment</u> / Non-pregnancy related visits	Not covered	<u>Cost sharing</u> does not apply to <u>In-Network preventive services</u> .
	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% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	Days 1-30: No charge Days 31-100: \$20 <u>copayment</u> /day	Not covered	100 visit maximum per calendar year Limited 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)	
	<u>Rehabilitation services</u>	\$20 <u>copayment</u>	Not covered	-----none-----
	<u>Habilitation services</u>	\$20 <u>copayment</u>	Not covered	-----none-----
	<u>Skilled nursing care</u>	Days 1-10: No charge Days 11-100: \$25 <u>copayment</u> /day	Not covered	100 visit maximum per calendar year. Prior Authorization is required.
	<u>Durable medical equipment</u>	No charge	Not covered	Prior Authorization is required for, but not limited to motorized wheelchairs, insulin infusion pumps, and CPAP machines.
	<u>Hospice services</u>	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.
	Children's eye exam	\$20 <u>copayment</u>	Not covered	-----none-----
If your child needs dental or eye care	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, 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	\$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
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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
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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
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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.