This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.deltahealthsystems.com or by calling **1-800-201-3150**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** individual / **$350** family **$100** individual for Medicare Primary Retirees Only Does not apply to the accident related expense benefit, prescriptions and second surgical opinions.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, $400 per admission to a non-network hospital for non-emergency admissions, $200 per admission to a network hospital and $600 per admission to a non-network hospital when the pre-service review requirements are not followed.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$400** individual for In-Network and **$700** individual for Non-Network. Once a covered person has incurred $2,000 in eligible expenses, the plan will pay 100% of covered, eligible charges for the remainder of the calendar year.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain preauthorization services, expenses which exceed UCR and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com/ca or call **1-800-201-3150** for a list of Network providers. For out of California, see www.firsthealth.com or call **1-800-201-3150** for a list of Network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	25% coinsurance	——————none——————
	Specialist visit	10% coinsurance	25% coinsurance	——————none——————
	Other practitioner office visit	10% coinsurance	25% coinsurance	Acupuncture care and chiropractic care are limited to 25 visits each per calendar year. Requests for additional treatment may be submitted for pre-service review. A lapse of 60 days between treatments will start a new treatment incident.
	Preventive care/screening/immunization	Not Covered	Not Covered	Benefits are provided for routine mammograms upon the referral of a physician.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	25% coinsurance	100% for Pre-Admission Testing performed on an outpatient basis (within 7 days of Inpatient surgery).
	Imaging (CT/PET scans, MRIs)	10% coinsurance	25% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medco.com	Generic drugs	$5/prescription (retail) and $3/prescription (mail order)	$5/prescription (retail) and $3/prescription (mail order)	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Brand Name Drugs	$12/prescription (retail) and $6/prescription(mail order)	$12/prescription (retail) and $6/prescription(mail order)	
	Non-Preferred Brand Name Drugs	Same as above	Same as above	
	Specialty Drugs	Same as above	Same as above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	25% coinsurance	Potentially cosmetic or investigative services require pre-authorization.
	Physician/surgeon fees	10% coinsurance	25% coinsurance	Potentially cosmetic or investigative services require pre-authorization
If you need immediate medical attention	Emergency room services	10% coinsurance	25% coinsurance	——————none——————
	Emergency medical transportation	10% coinsurance	10%coinsurance	——————none——————
	Urgent care	10% coinsurance	25% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	25% coinsurance	Pre-authorization is required.
	Physician/surgeon fee	10% coinsurance	25% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	25% coinsurance	————————none————————
	Mental/Behavioral health inpatient services	10% coinsurance	25% coinsurance	Pre-authorization is required from Care Resources, Inc.1-800-479-7721 or www.careresources.com
	Substance use disorder outpatient services	10% coinsurance	25% coinsurance	————————none————————
	Substance use disorder inpatient services	10% coinsurance	25% coinsurance	Pre-authorization is required from Care Resources, Inc. 1-800-479-7721 www.careresources.com
If you are pregnant	Prenatal and postnatal care	10% coinsurance	25% coinsurance	Coverage only for employees and covered spouses.
	Delivery and all inpatient services	10% coinsurance	25% coinsurance	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. Coverage only for employees and covered spouses.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	25% coinsurance	Services must be pre-authorized. Limited to 100 visits per calendar year. Services must be pre-authorized.
	Rehabilitation services	10% coinsurance	25% coinsurance	The services must be specifically prescribed by a physician as to type and duration and must be for improvement of bodily function. Occupational therapy is limited to 25 visits each per calendar year. Requests for additional treatment may be submitted for pre-service review. A lapse of 60 days between treatments will start a new treatment incident
	Habilitation services	10% coinsurance	25% coinsurance	The services must be specifically prescribed by a physician as to type and duration and must be for improvement of bodily function. Physical therapy is limited to 25 visits per calendar year. Requests for additional treatment may be submitted for pre-service review. A lapse of 60 days between treatments will start a new treatment incident
	Skilled nursing care	10% coinsurance	25% coinsurance	Services must be pre-authorized.
	Durable medical equipment	10% coinsurance	25% coinsurance	——————none——————
	Hospice service	No Charge	No Charge	Treatment after 60 days must be reviewed and authorized by the case manager.
If your child needs dental or eye care	Eye exam	Covered under the vision plan		Vision Service Plan (VSP) 1-800-877-7195 www.vsp.com.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Glasses	Covered under the vision plan		Vision Service Plan (VSP) 1-800-877-7195 www.vsp.com.
	Dental check-up	Covered under the dental plan		Delta Dental (Dental PPO) 1-800-765-6003 www.deltadentalins.com.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental Care (Adult) (except for the repair or alleviation of damage to natural teeth caused solely by accidental injury sustained while covered by this plan)
- Dental Care (Child) (except for the repair or alleviation of damage to natural teeth caused solely by accidental injury sustained while covered by this plan)
- Glasses (Child)
- Hearing Aids (except to correct a congenital birth defect of a dependent)
- Infertility Treatment
- Long-term care
- Non emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care (unless for treatment of a peripheral or metabolic disease)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (limited to 25 visits per calendar year, requests for additional treatment may be submitted for pre-service review. A lapse of 60 days between treatments will start a new treatment incident)
- Bariatric Surgery (when medically necessary for the purposes of weight reduction or weight control for morbid obesity)
- Chiropractic care (limited to 25 visits per calendar year, requests for additional treatment may be submitted for pre-service review. A lapse of 60 days between treatments will start a new treatment incident)
- Private Duty Nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-714-438-4727. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-800-201-3150. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,750
- **Patient pays:** $790

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$200
Copays	$0
Coinsurance	$400
Limits or exclusions*	$190
Total	**$790**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,520
- **Patient pays:** $880

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$370
Coinsurance	$90
Limits or exclusions	$220
Total	**$880**

*Limits or exclusions include possible over-the-counter items that may be needed to manage the condition.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.