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 **1-800-807-0820**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.deltahealthsystems.com **or** www.healthcare.gov

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network Providers: **$250** Individual/**$500** Family. Non-Network Providers: **$750** Individual/**$1,500** Family. Doesn't apply to preventive care, hospice, prescription drugs, chiropractic care, acupuncture or inpatient mental health or substance abuse care.	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?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Network providers: Medical and Mental Health / Substance Abuse Combined- $4,700 Individual/$9,400 Family; Prescription $900 Individual/$1,800 Family. Non-Network providers: Medical only $10,000 Individual /$20,000 Family.	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, health care this plan doesn't cover, balance-billed charges, penalties for failure to obtain pre-authorization for services	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. For a list of participating providers, see/call: Medical - www.anthem.com/ca or 1-800-807-0820; Chiro/Acupuncture - www.fusdchiro.com or 1-559-447-3375; Mental Health / Substance Abuse - www.fusdmentalhealth.com or 1-800-498-9055	If you use an in-network doctor or healthcare **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 do not 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 5. 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 an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit 20% coinsurance	40% coinsurance	----------None----------
	Specialist visit	$15/visit 20% coinsurance	40% coinsurance	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Other practitioner office visit	$5/visit for chiropractor, $20/visit for acupuncture.	40% coinsurance for chiropractor All costs above $20 for acupuncture.	Pre-Authorization required. Chiropractic: 28 visits max/Calendar Year, 10/month, 1/day. Non-Network Chiropractor 100 miles outside of Fresno only. Acupuncture: 20 visits max/Calendar Year, 10/month, 1/day.
	Preventive care/screening/immunization	No Charge	No Charge 40% for Well Baby Care	Coverage is limited to $300 annual max for non-network services.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	----------None----------
If you need drugs to treat your illness or condition For those in standard prescription plan. If you are enrolled in the Medicare approved plan, EnvisionRx*Plus,* see below. More information about **prescription drug coverage** is available at envisionrx.com.	Generic drugs (including covered over-the-counter drugs)	$10/prescription Retail and Mail Order	Not Covered	Retail: Covers up to 30 day supply; Up to 90 day supply for maintenance and non-maintenance drugs. Mail Order: Covers up to 90 day supply for non-maintenance drugs; Up to 180 days for maintenance drugs.
	Preferred Brand-Name drugs (including covered over-the-counter drugs)	$35/prescription Retail and Mail Order. Patient pays cost difference for brand with generic equivalent	Not Covered	
	Non-Preferred Brand-Name drugs (including covered over-the-counter drugs)	$50/prescription Retail and Mail Order.	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
For those enrolled in the Medicare approved plan, EnvisionRx*Plus.* More information about **prescription drug coverage** is available at www.envisionrxplus.com.	Generic drugs (including covered over-the-counter drugs)	$10/prescription Retail and Mail Order	Not Covered	Retail: Covers up to 30 day supply; Up to 90 day supply for maintenance and non-maintenance drugs. Mail Order: Covers up to 90 day supply for non-maintenance drugs; Up to 180 days for maintenance drugs.
	Brand drugs with generic equivalent (including covered over-the-counter drugs)	$35/prescription Retail and Mail Order. Patient pays cost difference for brand with generic equivalent	Not Covered	
	Brand drugs with no generic equivalent (including covered over-the-counter drugs)	$35/prescription Retail and Mail Order	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 plus 20% coinsurance	$100 plus 40% coinsurance	Coverage is limited to $1,000 per incident for non-network services. Pre-Authorization Required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------None----------
If you need immediate medical attention	Emergency room services	$100 plus 20% coinsurance	$100 plus 20% coinsurance	----------None----------
	Emergency medical transportation	No Charge for Air $100 plus 20% coinsurance for Ground	No Charge for Air $100 plus 20% coinsurance for Ground	----------None----------
	Urgent care	$35 plus 20% coinsurance	$35 plus 40% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-Authorization Required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10/visit	Not Covered	Pre-Authorization Required. Maximum 45 visits per calendar year.
	Mental/Behavioral health inpatient services	No charge	Not Covered	Pre-Authorization Required. Maximum 30 days per calendar year.
	Substance use disorder outpatient services	No charge	Not Covered	Pre-Authorization Required.
	Substance use disorder inpatient services	No charge	Not Covered	Pre-Authorization Required.
If you are pregnant	Prenatal and postnatal care	$15/visit	40% coinsurance	Dependent Children are only covered for preventive care services as defined under the Affordable Care Act. See http://www.healthcare.gov/center/regulations/prevention.html.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Dependent Children are not covered.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Pre-Authorization Required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Pre-Authorization Required.
	Habilitation services	20% coinsurance	40% coinsurance	Pre-Authorization Required.
	Skilled nursing care	20% coinsurance	40% coinsurance	Maximum of 120 days per calendar year. Pre-Authorization Required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-Authorization Required for DME over $2,000.
	Hospice service	No Charge	No Charge	Pre-Authorization Required.
If your child needs dental or eye care	Eye exam	Not Covered under medical plan	Not Covered under medical plan	----------None----------
	Glasses			----------None----------
	Dental check-up			----------None----------

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)	• Hearing Aids
• Infertility Treatment	• Long-term care	• Routine eye care (Adult)
• Routine Foot Care	• 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	• Bariatric Surgery	• Chiropractic Care (Non-Network 100 miles outside of Fresno only)
• Non-Emergency and Emergency care when traveling outside the U.S (contact Delta Health Systems)	•	

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 1-559-457-3520. 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 the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789. You can also contact Fresno Unified School District at 1-559-457-3596, or Delta Health Systems at 1-800-807-0820.

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 does provide minimum essential coverage.**

Questions: Call **1-800-807-0820** or visit us at **www.deltahealthsystems.com**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.deltahealthsystems.com** or **www.healthcare.gov** or call 1-800-807-0820 to request a copy.

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard. **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-559-457-3596. Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-559-457-3596.

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. These examples were completed using costs associated with individual coverage.

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** $5,758
- **Patient pays** $ 1,782

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	$250
Copays	$45
Coinsurance	$1,487
Limits or exclusions	$0
Total	**$1,782**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,920
- **Patient pays** $1,480

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	$250
Copays	$815
Coinsurance	$0
Limits or exclusions	$415
Total	**$1,480**

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.