

 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, visit [www.ihmbhealthconnect.com](http://www.ihmbhealthconnect.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.ihmbhealthconnect.com](http://www.ihmbhealthconnect.com) or call 1-559-457-3520 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<u>Network Providers</u> : \$1,000 Individual/\$2,000 Family. <u>Out-of-Network Providers</u> : \$3,000 Individual/\$6,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> , <u>hospice</u> , <u>prescription drugs</u> , chiropractic care ( <u>network providers</u> ), acupuncture, ambulance, mental health, and substance abuse care are covered before you meet your <u>deductible</u> .	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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	Yes. <u>Out-of-network</u> chiropractic care (provided through PhysMetrics) has a separate \$100 calendar year <u>deductible</u> .	You must pay all of the costs for these services up to the specific deductible amount before this <u>plan</u> begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<u>Network Providers</u> : Medical and Mental Health / Substance Abuse Combined - \$5,700 Individual/\$11,400 Family; Prescription \$900 Individual/\$1,800 Family. <u>Out-of-Network Providers</u> : Medical only - \$12,000 Individual/\$24,000 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , health care this <u>plan</u> doesn't cover, <u>balance-billing</u> charges, penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. For a list of <u>network providers</u> , call/see: Medical - 1-800-807-0820 or <a href="https://www.aetnaresource.com/p/FresnoUSD">https://www.aetnaresource.com/p/FresnoUSD</a> ; Mental Health / Substance Abuse - 1-888-425-	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an


	4800 or <a href="http://www.fusdmhsa.com">www.fusdmhsa.com</a> . Chiropractic / Acupuncture – 1-877-519-8839 or <a href="http://www.fusdchiro.com">www.fusdchiro.com</a> .	<u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. Exceptions apply, please review the “Your Rights And Protections Against Surprise Medical Bills” notice at <a href="https://www.deltahealthsystems.com/Home/Resources">https://www.deltahealthsystems.com/Home/Resources</a> , under Other HealthCare Regulations.
<b>Do you need a referral to see a specialist?</b>	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)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider’s office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /office visit, and 25% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$25 <u>copay</u> /office visit, and 25% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren’t <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Genetic Testing is not covered.
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition; for those enrolled in the commercial prescription plan.</b>  (If you are enrolled in the Medicare Part D Prescription Drug Plan with Elixir Insurance)	Tier 1 – Low-cost Generic drugs used for treating high cholesterol, high blood pressure, diabetes, and depression	No charge	Not covered	All maintenance medications must be filled with a 90-day supply through Elixir Mail , Rite Aid, Walgreens, or Costco retail pharmacy.
	Tier 2 - Generic drugs	\$10 <u>copay</u> /30-day supply <u>Deductible</u> does not apply	Not covered	30-day and 90-day supplies at retail; 90-day supplies at mail order. 90-day supply: Requires two 30-day copays..
	Tier 3 - Preferred brand name drugs	\$35 <u>copay</u> /30-day supply <u>Deductible</u> does not apply	Not covered	The prescription <u>plan</u> uses Elixir’s Select Formulary. The formulary list is available at

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
Company, see below.)  More information about <b>prescription drug coverage</b> is available at <a href="http://www.ElixirSolutions.com">www.ElixirSolutions.com</a>	Tier 4 - Non-preferred brand name drugs	\$50 <u>copay</u> /30-day supply <u>Deductible</u> does not apply	Not covered	<a href="http://www.ElixirSolutions.com">www.ElixirSolutions.com</a> .  Patient pays cost difference for brand with generic equivalent, unless waived with an approved Letter of Medical Necessity. Cost difference does not apply to out-of-pocket maximum.
<b>For those enrolled in the Medicare Part D Prescription Drug Plan with Elixir Insurance Company.</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.envisionrxplus.com">www.envisionrxplus.com</a>	Generic drugs	\$10 <u>copay</u> /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.
	Preferred brand name drugs	\$35 <u>copay</u> /prescription Retail and Mail Order	Not Covered	Mail Order: Covers up to 90-day supply for non-maintenance drugs; Up to 180-days for maintenance drugs.
	Non-preferred brand name drugs	\$35 <u>copay</u> /prescription Retail and Mail Order	Not Covered	Patient pays cost difference for brand with generic equivalent, unless waived with an approved Letter of Medical Necessity.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> plus 25% <u>coinsurance</u>	Not Covered	<u>Preauthorization by Aetna is required for certain outpatient procedures and are CPT (Procedure) Code driven. Please reference Aetna's National Precertification List (NPL) available at <a href="https://www.aetnaresource.com/p/FresnoUSD">https://www.aetnaresource.com/p/FresnoUSD</a>. If preauthorization is not obtained, benefits could be denied or reduced.</u>
	Physician/surgeon fees	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>  Please review the "Your Rights And Protections Against Surprise Medical Bills" notice at <a href="https://www.deltahealthsys.com/Home/Resources">https://www.deltahealthsys.com/Home/Resources</a> ,	Emergency room care	\$100 <u>copay</u> plus 25% <u>coinsurance</u>	\$100 <u>copay</u> plus 25% <u>coinsurance</u>	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	\$100 <u>copay</u> plus 25% <u>coinsurance</u> for Ground; No Charge for Air <u>Deductible</u> does not apply	\$100 <u>copay</u> plus 25% <u>coinsurance</u> for Ground; No Charge for Air <u>Deductible</u> does not apply	<u>Preauthorization</u> by Aetna is required for transportation by fixed-winged aircraft. If <u>preauthorization</u> is not obtained, benefits could be denied or reduced.
	<u>Urgent care</u>	\$35 <u>copay</u> plus 25%	\$35 <u>copay</u> plus 50%	None

 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)	Out-of-Network Provider (You will pay the most)	
under Other HealthCare Regulations.		<u>coinsurance</u>	<u>coinsurance</u>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> by Aetna is required. If <u>preauthorization</u> is not obtained, benefits could be denied or reduced.
	Physician/surgeon fees	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>  (provided through Halcyon)	Mental/Behavioral Health Outpatient services	\$10 <u>copay</u> /visit. <u>Deductible</u> does not apply.	Not Covered	<u>Preauthorization</u> by Halcyon is required. Maximum 60 visits per calendar year.
	Mental/Behavioral Health Inpatient services	No Charge	Not Covered	<u>Preauthorization</u> by Halcyon is required. Maximum 45 days per calendar year.
	Substance Abuse Outpatient services	No Charge	Not Covered	<u>Preauthorization</u> by Halcyon is required.
	Substance Abuse Inpatient services	No Charge	Not Covered	<u>Preauthorization</u> by Halcyon is required.
<b>If you are pregnant</b>	Office visits	\$25 <u>copay</u> /office visit, and 25% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Dependent Children are only covered for <u>preventive services</u> as defined under the Affordable Care Act.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Rehabilitation services</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> by Aetna is required for inpatient confinements. If <u>preauthorization</u> is not obtained, benefits could be denied or reduced.
	<u>Habilitation services</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Maximum 120 days per calendar year. <u>Preauthorization</u> by Aetna is required. If <u>preauthorization</u> is not obtained, benefits could be denied or reduced.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> by Aetna is required for certain services. If <u>preauthorization</u> is not obtained,

 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)	Out-of-Network Provider (You will pay the most)	
				benefits could be denied or reduced.
	Hospice services	No Charge	No Charge	
If your child needs dental or eye care	Children's eye exam	Not Covered under Medical Plan	Not Covered under Medical Plan	Provided through MESVision
	Children's glasses			Provided through MESVision
	Children's dental check-up			Provided through Delta Dental or UHC

### 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.)

• Cosmetic Surgery	• Dental Care (Adult) (Provided through Delta Dental or UHC)	• Genetic Testing
• Hearing Aids	• Infertility Treatment	• Long-Term Care
• Routine Eye Care (Adult) (Provided through MESVision)	• Routine Foot Care	• Weight Loss Programs

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Acupuncture (through PhysMetrics)	• Bariatric Surgery (Preauthorization by Aetna is required.)	• Chiropractic Care (through PhysMetrics)
• Non-emergency care when traveling outside United States	• Private-duty Nursing (Preauthorization by Aetna is required.)	

**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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://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](http://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: Delta Health Systems at 1-800-807-0820.

### 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:**

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.

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-559-457-3596.

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

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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 \$1,000
- Specialist copayment \$25
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

**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)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$10
Coinsurance	\$2,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,970</b>

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

- The plan's overall deductible \$1,000
- Specialist copayment \$25
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

**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)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$280
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,680</b>

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

- The plan's overall deductible \$1,000
- Specialist copayment \$25
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

**This EXAMPLE event includes services like:**  
Emergency room care (including medical supplies)  
Diagnostic test (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (physical therapy)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$200
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,600</b>