



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 1-800-291-0726.

Important Questions	Answers	Why this Matters:
<p>What is the overall deductible?</p>	<p>For the fiscal year period July 1 to June 30, the annual deductible is: In-network PPO Participating Provider: \$500/person; \$1,500/family Non-Participating Provider: \$1,500/person; \$3,000/family Does not apply to preventive care, and outpatient prescription drugs. Copayments do not count toward the deductible.</p>	<p>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.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>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.</p>
<p>Is there an out-of-pocket limit on my expenses?</p>	<p>Yes, for the fiscal year period July 1 to June 30, for the Medical Plan, the annual out-of-pocket limit is: In-network PPO Participating Provider: \$5,000/person; \$10,000/family. See also the separate out-of-pocket limit for cost-sharing for outpatient drugs explained on page 3. Non-Participating Provider: No limit.</p>	<p>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 pay for health care expenses.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>In-network PPO Participating Provider: For the Medical Plan, premiums, balance-billed charges, health care this plan does not cover, charges in excess of benefit maximums and allowed charges, outpatient retail/mail order prescription drug expenses (which have a separate Out-of-Pocket Limit), and out-of-network deductibles, copayments and coinsurance except ER visit in cases of an emergency do not count toward the out-of-pocket limit. Non-Participating Provider: has no out-of-pocket limit.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>

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City of Stockton: Modified Employee Medical Plan

Coverage Period: 07/01/2016 – 6/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: PPO

Does this plan use a network of providers ?	Yes. For a list of in-network Participating providers , see www.anthem.com/ca or call 1-800-274-7767.	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 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 in-network PPO Participating **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	20% co-insurance.	50% co-insurance.	---none---
	Specialist visit	20% co-insurance.	50% co-insurance.	---none---
	Other practitioner office visit	20% co-insurance.	50% co-insurance.	No precertification is required for Chiropractic services.
	Preventive care/screening /immunization	No charge.	50% co-insurance.	Plan covers ACA-required preventive services and supplies.

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If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance.	50% co-insurance.	---none---
	Imaging (CT/PET scans, MRIs)	20% co-insurance.	50% co-insurance.	---none---
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available from Caremark at www.caremark.com or call 1-888-895-2557.	Generic drugs	Retail Pharmacy for 30-day supply: \$10 copay; Mail Order for 90-day supply: \$20 copay. Prescription contraceptives: No charge for generic drugs.	No coverage.	If the cost of the drug is less than the copay, you pay just the drug cost.
	Preferred brand (formulary) drugs	Retail Pharmacy for 30-day supply: \$35 copay; Mail Order for 90-day supply: \$70 copay. Prescription contraceptives: No charge for brand drug if generic drug is medically inappropriate.	No coverage.	If the cost of the drug is less than the copay, you pay just the drug cost.
	Non-preferred brand (non-formulary) drugs	Retail Pharmacy for 30-day supply: 50% co-insurance; Mail Order for 90-day supply: 50% coinsurance.	No coverage.	Specialty drugs require pre-approval by calling Caremark at 1-866-387-2573. The <u>out-of-pocket limit on outpatient drugs</u> is the most you pay for covered generic, preferred brand, non-preferred brand & specialty drugs from in-network retail & mail order locations per fiscal year period July 1 to June 30, and is \$1,600/person; \$3,200/family (these amounts may be adjusted in accordance with law).
	Specialty drugs	For up to a 30-day supply, you pay the same as listed under Retail Pharmacy, noted above.	No coverage.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance.	50% co-insurance.	---none---
	Physician/surgeon fees	20% co-insurance.	50% co-insurance.	---none---

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If you need immediate medical attention	Emergency room services	20% co-insurance.	20% co-insurance.	You pay 50% coinsurance if ER visit is not an emergency.
	Emergency medical transportation	20% co-insurance.	50% co-insurance.	---none---
	Urgent care	20% co-insurance.	50% co-insurance.	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	\$75 copay per admission plus 20% co-insurance.	\$200 copay per admission plus 50% co-insurance.	Elective hospital admission requires precertification.
	Physician/surgeon fee	20% co-insurance.	50% co-insurance.	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance.	50% co-insurance.	---none---
	Mental/Behavioral health inpatient services	\$75 copay per admission plus 20% co-insurance.	\$200 copay per admission plus 50% co-insurance.	Elective hospital admission requires precertification.
	Substance use disorder outpatient services	20% co-insurance.	50% co-insurance.	---none---
	Substance use disorder inpatient services	\$75 copay per admission plus 20% co-insurance.	\$200 copay per admission plus 50% co-insurance.	Elective hospital admission requires precertification.
If you are pregnant	Prenatal and postnatal care	No charge.	50% co-insurance.	No coverage for pregnancy of a dependent child unless required by law.
	Delivery and all inpatient services	Hospital: \$75 copay per admission plus 20% co-insurance. Physician: 20% co-insurance.	\$200 copay per admission plus 50% co-insurance.	Precertification required if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section.
If you need help recovering or have other special health needs	Home health care	20% co-insurance.	Not covered.	---none---
	Rehabilitation services	20% co-insurance.	50% co-insurance.	Covered for restoration of a disability where there is a reasonable expectation of significant improvement.
	Habilitation services	20% co-insurance.	50% co-insurance.	Speech therapy payable if for a non-curable developmental disorder such as autism or mental retardation.
	Skilled nursing care	\$75 copay per admission plus 20% co-insurance.	\$200 copay per admission plus 50% co-insurance.	Precertify admission. Payable only if transferred directly from a covered inpatient stay.

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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
	Durable medical equipment	20% co-insurance.	50% co-insurance.	---none---
	Hospice service	20% co-insurance.	Not covered.	Covered if terminally ill.
If your child needs dental or eye care	Eye exam	No charge when obtained during a preventive care office visit.	No coverage.	You pay 100% of these expenses unless the exam is performed during a covered preventive care office visit.
	Glasses	Not covered.	Not covered.	You pay 100% of these expenses.
	Dental check-up	Not covered.	Not covered.	You pay 100% of these expenses.

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) (Child)
- Eyeglasses (Adult) (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult) (Child)
- 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 (unless necessary due to life-threatening condition of morbid obesity).
- Chiropractic services
- Habilitation services excluded, other than speech therapy for a non-curable developmental disorder.
- Infertility treatment covered except if it involves invitro fertilization.

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 1-800-291-0726. 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.

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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 Medical Plan Claims Administrator (Delta Health Systems) at 1-800-291-0726.

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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-291-0726.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-291-0726.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-291-0726.

—————*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 \$5,710
- Patient pays \$1,830

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	\$500
Copays	\$170
Coinsurance	\$1,130
Limits or exclusions	\$30
Total	\$1,830

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

- Amount owed to providers: \$5,400
- Plan pays \$4,040
- Patient pays \$1,360

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	\$500
Copays	\$400
Coinsurance	\$380
Limits or exclusions	\$80
Total	\$1,360

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.

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