

 **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. 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 or call 1-559-457-3520 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network Providers</u> : \$250 Individual/\$500 Family. <u>Out-of-Network Providers</u> : \$750 Individual/\$1,500 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	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 <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	<u>Network Providers</u> : Medical and Mental Health / Substance Abuse Combined - \$2,100 Individual/\$4,200 Family; Prescription \$400 Individual/\$800 Family. <u>Out-of-Network Providers</u> : Medical only - \$10,000 Individual/\$20,000 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.
What is not included in the out-of-pocket limit?	<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> .
Will you pay less if you use a network provider?	Yes. For a list of <u>network providers</u> , call/see: Medical - 1-800-807-0820 or https://www.aetnaresource.com/p/FresnoUSD ; 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 charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an


	4800 or www.fusdmhsa.com . Chiropractic / Acupuncture – 1-877-519-8839 or www.fusdchiro.com .	<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 https://www.deltahealthsystems.com/Home/Resources , under Other HealthCare Regulations.
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)	Out-of-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	\$15 <u>copay</u> /office visit	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$15 <u>copay</u> /office visit	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	40% <u>coinsurance</u>	Genetic Testing is not covered.
	Imaging (CT/PET scans, MRIs)	No charge	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition; for those enrolled in the <u>commercial prescription plan</u>. More information about <u>prescription drug coverage</u> is available at www.ElixirSolutions.com	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 plan uses Elixir’s Select Formulary. The formulary list is available at www.ElixirSolutions.com .
	Tier 4 - Non-preferred brand name drugs	\$50 <u>copay</u> /30-day supply <u>Deductible</u> does not apply	Not covered	Patient pays cost difference for brand with generic equivalent, unless waived with an approved Letter

 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)	
				of Medical Necessity. Cost difference does not apply to <u>out-of-pocket</u> maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not Covered	<u>Preauthorization</u> by Aetna is required for certain outpatient procedures and are CPT (Procedure) Code driven. Please reference Aetna's National Precertification List (NPL) available at https://www.aetnaresource.com/p/FresnoUSD . If <u>preauthorization</u> is not obtained, benefits could be denied or reduced.
	Physician/surgeon fees	No charge	40% <u>coinsurance</u>	None
If you need immediate medical attention Please review the "Your Rights And Protections Against Surprise Medical Bills" notice at https://www.deltahealthsystems.com/Home/Resources , under Other HealthCare Regulations.	Emergency room care	\$100 <u>copay</u>	\$100 <u>copay</u>	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	\$100 <u>copay</u> for Ground; No Charge for Air <u>Deductible</u> does not apply	\$100 <u>copay</u> for Ground; No Charge for Air <u>Deductible</u> does not apply	<u>Preauthorization</u> by Aetna is required for transportation by fixed-wing aircraft. If <u>preauthorization</u> is not obtained, benefits could be denied or reduced.
	<u>Urgent care</u>	\$35 <u>copay</u>	\$35 <u>copay</u> plus 40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% <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	No charge	40% <u>coinsurance</u>	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)	
If you need mental health, behavioral health, or substance abuse services (provided through SimpleBehavioral)	Mental/Behavioral Health Outpatient services	\$10 <u>copay</u> /visit. <u>Deductible</u> does not apply	40% <u>coinsurance</u>	<u>Preauthorization</u> by SimpleBehavioral is required for certain outpatient services.
	Mental/Behavioral Health Inpatient services	No Charge	40% <u>coinsurance</u>	<u>Preauthorization</u> by SimpleBehavioral is required.
	Substance Abuse Outpatient services	No Charge	40% <u>coinsurance</u>	<u>Preauthorization</u> by SimpleBehavioral is required for certain outpatient services.
	Substance Abuse Inpatient services	No Charge	40% <u>coinsurance</u>	<u>Preauthorization</u> by SimpleBehavioral is required.
If you are pregnant	Office visits	\$15 <u>copay</u> /office visit	40% <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	No charge	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	40% <u>coinsurance</u>	Dependent Children are only covered for <u>preventive services</u> as defined under the Affordable Care Act.
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	40% <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>Rehabilitation services</u>	No charge	40% <u>coinsurance</u>	
	<u>Habilitation services</u>	No charge	40% <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>Skilled nursing care</u>	No charge	40% <u>coinsurance</u>	
	<u>Durable medical equipment</u>	No charge	40% <u>coinsurance</u>	<u>Preauthorization</u> by Aetna is required for certain services. If <u>preauthorization</u> is not obtained, benefits could be denied or reduced.
	<u>Hospice services</u>	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 Vision Service Plan (VSP)
	Children's glasses			Provided through Vision Service Plan (VSP)
	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 VSP) | • 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.)

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|---|---|---|
| • 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. 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: 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.

—————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)

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>co-payment</u>	\$0

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$320

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>co-payment</u>	\$0

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$670

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>co-payment</u>	\$0

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$550