
 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 web.peralta.edu/benefits or call 1-510-466-7229. 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.cciio.cms.gov or call 1-510-466-7229 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall deductible? | \$100 person/ \$300 family (3 individuals) | Generally, you must pay all of the costs from providers up to the deductible amount before this plan 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 . |
| Are there services covered before you meet your deductible? | Deductible doesn't apply to emergency room services, ambulance services, the prescription drug program and the following preferred provider services: office visits, chiropractic care and preventive care. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | Medical: \$300 person/ \$900 family (3 individuals) Prescription Drugs from Participating Pharmacies: \$6,300 person/ \$12,300 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Penalties for failure to pre-certify services, drug copays from non-participating pharmacies, premiums , balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| Will you pay less if you use a network provider ? | Yes. See www.anthem.com/ca or call 1-866-280-4120 for a list of network providers. | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | No. | You can see the specialist you choose without a referral . |

 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 |
|--|--|---|--|--|
| | | Preferred Provider (You will pay the least) | Nonpreferred 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 copay /visit; (Deductible does not apply) | Not covered | None |
| | Specialist visit | | | |
| If you have a test | Preventive care/screening/immunization | No charge (Deductible does not apply.) | Not covered | Coverage is limited to 1 mammogram/calendar year age 35 & over, 1 gyn exam & pap smear/calendar year and 1 PSA test/calendar year age 40 & over. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| | Diagnostic test (x-ray, blood work) | No charge | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | | | |

* For more information about limitations and exceptions, see the plan or policy document at web.peralta.edu/benefits.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com . | Generic drugs | \$15 copay for retail and \$5 copay mail order/prescription | | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). If a drug is purchased from a non-participating pharmacy or from a participating pharmacy without an ID card, the covered person must pay the usual copay, plus the difference in cost between the participating and non-participating pharmacy. If there is no generic equivalent for a brand name drug, the generic copay will apply. |
| | Preferred brand drugs | \$20 copay for retail and \$5 copay mail order/prescription | | |
| | Non-preferred brand drugs | \$20 copay for retail and \$5 copay mail order/prescription | | |
| | Specialty drugs | Same as Generic drugs, Preferred brand drugs or Non-preferred brand drugs above, as applicable | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | None |
| | Physician/surgeon fees | No charge | Not covered | None |
| If you need immediate medical attention | Emergency room care | \$35 copay /visit; (Deductible does not apply) | \$35 copay /visit; (Deductible does not apply) | Copay waived if admitted. |
| | Emergency medical transportation | No charge; (Deductible does not apply) | No charge; (Deductible does not apply) | None |
| | Urgent care | \$15 copay /visit | Not covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | Not covered | Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%. |
| | Physician/surgeon fees | No charge | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$15 copay /visit | Not covered | No coverage for biofeedback. |
| | Inpatient services | No charge | Not covered | Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%. |
| If you are pregnant | Office visits | \$15 copay /initial visit; (Deductible does not apply) | Not covered | None |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|--|
| | | Preferred Provider (You will pay the least) | Nonpreferred Provider (You will pay the most) | |
| | Childbirth/delivery professional services | No charge | Not covered | Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (<i>i.e.</i> , ultrasound.) |
| | Childbirth/delivery facility services | No charge | Not covered | None |
| If you need help recovering or have other special health needs | Home health care | No charge | Not covered | Coverage is limited to 100 visits/calendar year. |
| | Rehabilitation services | No charge | Not covered | None |
| | Habilitation services | No charge | Not covered | Coverage is limited to attention deficit disorders. |
| | Skilled nursing care | No charge | Not covered | Coverage is limited to 100 days/calendar year. |
| | Durable medical equipment | No charge | Not covered | None |
| | Hospice services | No charge | Not covered | None |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | No coverage for eye exams under medical. |
| | Children's glasses | Not covered | Not covered | No coverage for glasses under medical. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental check-ups under medical. |

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](#).)

- Biofeedback therapy;
- Dental care;
- Routine foot care, and
- Cosmetic surgery;
- Long-term 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;
- Hearing aids;
- Private-duty nursing, and
- Bariatric surgery (for morbid obesity only);
- Infertility treatment;
- Routine eye care.
- Chiropractic care;
- Non-emergency care when traveling outside the U.S.;

* For more information about limitations and exceptions, see the plan or policy document at web.peralta.edu/benefits.

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 x61565 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: Peralta Community College District at 1-510-466-7229, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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](#).

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 [deductible](#) \$100
- [Specialist copayment](#) \$15
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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 | \$12,840 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$100 |
| Copayments | \$90 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$250 |

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$15
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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 | \$7,460 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$100 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$360 |

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$15
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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 | \$2,010 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$100 |
| Copayments | \$50 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$150 |