




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](http://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](http://www.cciio.cms.gov) or call 1-510-466-7229 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><b>\$100</b> person/<b>\$300</b> family (3 individuals)</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay.</p> <p>If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Deductible doesn't apply to emergency room services, ambulance services, the prescription drug program and the following <b>preferred provider</b> services: office visits, chiropractic care and preventive care.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.</p> <p>For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p><b>Preferred Providers:</b>  <b>\$300</b> person/<b>\$900</b> family (3 individuals)</p> <p><b>Nonpreferred Providers:</b>  <b>\$1,000</b> person/<b>\$3,000</b> family</p> <p><b>Prescription Drugs from Participating Pharmacies:</b>  <b>\$6,300</b> person/<b>\$12,300</b> family</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.</p> <p>If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p>Penalties for failure to pre-certify services, drug copays from non-participating pharmacies, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

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

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /visit; ( <a href="#">Deductible</a> does not apply)	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit			
	<a href="#">Preventive care/screening/immunization</a>	No charge ( <a href="#">Deductible</a> does not apply.)	<u>Well Child Care:</u> Not covered; <u>Adult Preventive Care:</u> 20% <a href="#">coinsurance</a>	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 <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)			

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> .	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		
	<a href="#">Specialty drugs</a>	Same as Generic drugs, Preferred brand drugs or Non-preferred brand drugs above, as applicable		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$35 <a href="#">copay</a> /visit; ( <a href="#">Deductible</a> does not apply)	\$35 <a href="#">copay</a> /visit; ( <a href="#">Deductible</a> does not apply)	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	No charge; ( <a href="#">Deductible</a> does not apply)	No charge; ( <a href="#">Deductible</a> does not apply)	None
	<a href="#">Urgent care</a>	\$15 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	20% <a href="#">coinsurance</a>	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	20% <a href="#">coinsurance</a>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	No coverage for biofeedback.
	Inpatient services	No charge	20% <a href="#">coinsurance</a>	Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%.
<b>If you are pregnant</b>	Office visits	\$15 <a href="#">copay</a> /initial visit; ( <a href="#">Deductible</a> does not apply)	20% <a href="#">coinsurance</a>	None

\* For more information about limitations and exceptions, see the plan or policy document at [web.peralta.edu/benefits](http://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)	
	Childbirth/delivery professional services	No charge	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC ( <i>i.e.</i> , ultrasound.)
	Childbirth/delivery facility services	No charge	20% <a href="#">coinsurance</a>	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	20% <a href="#">coinsurance</a>	Coverage is limited to 100 visits/calendar year.
	<a href="#">Rehabilitation services</a>	No charge	20% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	No charge	20% <a href="#">coinsurance</a>	Coverage is limited to attention deficit disorders.
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">coinsurance</a>	Coverage is limited to 100 days/calendar year.
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	No charge	20% <a href="#">coinsurance</a>	None
<b>If your child needs dental or eye care</b>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Biofeedback therapy;</li> <li>Cosmetic surgery;</li> </ul>	<ul style="list-style-type: none"> <li>Dental care;</li> <li>Long-term care;</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care;</li> <li>Weight-loss programs, and</li> <li>Well child care by a <a href="#">nonpreferred provider</a>.</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Acupuncture;</li> <li>Bariatric surgery (for morbid obesity only);</li> <li>Chiropractic care;</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids;</li> <li>Infertility treatment;</li> <li>Non-emergency care when traveling outside the U.S.;</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing, and</li> <li>Routine eye care.</li> </ul>

\* For more information about limitations and exceptions, see the plan or policy document at [web.peralta.edu/benefits](http://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](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: 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](http://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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$70
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$230</b>

**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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
---------------------------	----------------

**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
<b>The total Joe would pay is</b>	<b>\$360</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,010</b>
---------------------------	----------------

**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
<b>The total Mia would pay is</b>	<b>\$150</b>