2013

MEANINGFUL NOTICES MANUAL

Table of Contents

Prepared by PSW Benefit Resources
Rev. (8-13-2013)

Your Rights Under the Women's Health and Cancer Rights Act

All covered family members must read this notice summarizing your rights under the Women's Health and Cancer Rights Act.

What is the Women's Health and Cancer Rights Act?
The Women's Health and Cancer Rights Act (WHCRA) provides protections for mastectomy patients who choose to have breast reconstruction in connection with a mastectomy. The WHCRA applies only to those group health plans and health insurers that cover benefits for mastectomies; *it does not require* health plans to pay for mastectomies. But for plans that do provide coverage for mastectomies, the WHCRA requires coverage for reconstruction as well. According to the U.S. Department of Labor, the WHCRA is not limited to cancer patients; this law should cover anyone seeking reconstruction after a mastectomy for any reason.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses (e.g. breast implant); and
4. Treatment for physical complications of the mastectomy, including lymph edema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. **NOTE: State laws *may* broaden federal WHCRA rights. Please read your Summary Plan Description or contact our benefits broker, PSW Benefit Resources at 1.877.866.2623, for complete details on your plan benefits.** More information about the WHCRA may be obtained by calling the Employee Benefits Security Administration of the U.S. Department of Labor toll-free at: 1.866.444.3272.

Notification of Pre-Existing Condition Limitation

A group health plan makes coverage effective on the first of the month following your initial date of hire and on each ***open enrollment period*** following. Open enrollment generally occurs in February and August of each calendar year for adjunct employees and in May of each year for all other employees.

The District's self-funded plan administered by CoreSource imposes a **6-month** maximum pre-existing condition exclusion (18 months for late enrollees) and uses a **6-month** look back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a pre-existing condition exclusion for all eligible participants age 19 and over. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment recommended or received within a **6-month period**. Generally, this **6-month period** ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 6 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the ***6 months*** (18 months if you are late enrollee) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to: **Jennifer Seibert, District Benefits Manager; Peralta Community College District; 333 East 8th Street, Oakland, CA 94606; Phone number: 510.466.7229; Email: jseibert@peralta.edu**

Overage Dependent Status (aka Michelle's Law)

This mandate requires an insurance company to continue medical coverage for an overage dependent that is away from school due to a medical leave of absence. This mandate requires that a dependent child's coverage can continue for 12 months or until the date on which the coverage is scheduled to end according to the terms and conditions of the plan, whichever occurs first. After this time, if the overage dependent is unable to return to school, he or she will need to apply for individual coverage through COBRA, HIPAA or for disabled coverage under the parent/guardian's plan. An employee is required to notify the insurance company **AND** the employer within 30 days before the leave begins if the leave is known about in advance or within 30 days after the start date of an unplanned medical leave of absence. The carrier will also request a signed note from the attending physician stating the medical necessity, the diagnosis code, leave start date (and end date if known) and the physicians name, date and signature.

Statement of Rights Under the Newborns' & Mothers' Health Protection Act

Under Federal law, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child may not be limited to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. Federal law does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In addition, Federal law states that carriers may NOT require providers / members to obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of **other** health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment **within 30 days** after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment **within 30 days** after the marriage, birth, adoption, or placement for adoption.

Furthermore, if you are an employee who is eligible for coverage but not enrolled, you shall be eligible to enroll for coverage within 60 days after (a) becoming ineligible for coverage under a Medicaid, Children's Health Insurance Plan (CHIP); or (b) being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan. Employers that sponsor group health plans must notify employees of any premium assistance that is available to them under a Medicaid or CHIP plan with respect to coverage under the plan.

To request special enrollment or obtain more information, please contact **Jennifer Seibert, District Benefits Manager; Peralta Community College District; 333 East 8th Street, Oakland, CA 94606; Phone number: 510.466.7229; Email:** jseibert@peralta.edu

Lifetime Limitations

The lifetime limit on the dollar value of benefits under the **Peralta Self Funded PPO Plan or the Kaiser HMO Plan** no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. This does not apply to Retiree Grandfathered plans.

For more information contact **Jennifer Seibert, District Benefits Manager; Peralta Community College District; 333 East 8th Street, Oakland, CA 94606; Phone number: 510.466.7229; Email:** jseibert@peralta.edu

Medicare Part D Fact Sheet and Annual Notification
Please review this document carefully.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?
If you are retired from Peralta employment, receive prescription drug coverage through the District as a retiree or dependent thereof, and participate in a Medicare drug plan outside of your Peralta group insurance plan, your current PCCD coverage may be affected.

- If you elect Kaiser Senior Advantage, you are automatically signed up for Medicare Part D at the time of your enrollment. All Medicare benefits are assigned to Kaiser when you enroll in Kaiser Senior Advantage. It is possible that you will be responsible for a monthly Medicare Part D premium payment. A small group, fewer than 5% of all people with Medicare, may pay a monthly premium for Medicare Part D coverage based upon their income. This includes Part D coverage you receive from a Medicare Advantage Plan that includes drug coverage. If your modified adjusted gross income as reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain limit, you'll pay an extra amount in addition to your plan premium. Usually, the extra amount is deducted from your Social Security check. If not, then the responsibility to make this payment is yours. In accordance with Medicare regulations, Kaiser will terminate the prescription drug benefit affiliated with Kaiser Senior Advantage if the Medicare D premium is not paid.
- If you are enrolled in the PCCD, Self-Funded Plan, and elect to sign up for Medicare Part D, your prescription coverage under the District WILL be canceled. If you do decide to join a Medicare drug plan and drop your current PCCD prescription coverage, be aware that you and your dependents will be unable to get this coverage back until the next open enrollment period.

The District does not reimburse the Medicare D premium tax paid by "Higher Income Beneficiaries" as defined by the Social Security Administration. Criteria for the tax assessment can be found in the publication SSA Publication 05-10536 Medicare Premiums: Rules for Higher Income Beneficiaries. http://www.ssa.gov/pubs/10536.html#a0=-1

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with PCCD and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…
For further information call the PCCD Benefits Office at 510.466.7229. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through PCCD changes. You also may request a copy of this notice at any time.

For More Information About Medicare Premiums:
Given the complexity of each individual's circumstances, contact Medicare directly regarding the **accuracy** of the tax amount or the **timing** or the **method** of your payments to the Medicare A, B & D programs.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1.800.MEDICARE 1.800.633.4227. TTY users should call 1.877.486.2048.

If you have limited income and resources, help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213. TTY users should call 1.800.325.0778.

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: July 30, 2013 -- Name of Entity/Sender: PCCD District Benefits Office--Phone Number: 510.466.7229

Medicare—Part D Fact Sheet and Annual Notification
Please review this document carefully.

Important Notice from PCCD About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PCCD and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug **coverage is at the end of this notice.**

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PCCD has determined that the prescription drug coverage offered by Kaiser and CoreSource are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Highlights of the 2013 Medicare Prescription Drug benefit:

- Minimal monthly premium (varies depending on the plan you choose)
- $325 annual deductible in 2013.
- Medicare will cover 75% of the drug cost up to $2,970 (annually) in 2013.
- Any costs between the $2,970 and $4,750 in 2013.
- When an employee drug bill exceeds $4,750 in 2013, Medicare will cover 95% of any costs above that ceiling.

Medicare, Kaiser and Caremark Comparison for PCCD Retirees

Benefits	Medicare Part D	Kaiser	Caremark (through CoreSource medical coverage)
Co-pay	25%	$1 - $15*	$1 - $15*
Deductible	$325	None	None

*Co-pays are based on formulary determination and whether or not mail order is used.
*The District reimburses co-pays in accordance prevailing Collective Bargaining Agreements.

As you can see, your existing coverage is on average at least as good as standard Medicare prescription drug coverage. You can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

When Can You Join A Medicare Drug Plan?

Although your District-sponsored plans **are better than** the federal Medicare D Plan, we are required to inform you that you can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15th through Dec. 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

GENERAL NOTICE OF COBRA CONTINUATION RIGHTS

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is: **Jennifer Seibert, District Benefits Manager, Peralta Community College District, 333 East 8th Street, Oakland CA 94606, (510) 466-7229**

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies; or
- Your spouse's hours of employment are reduced; or
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent – employee dies; or
- The parent – employee's hours of employment are reduced; or
- The parent – employee's employment ends for any reason other than his or her gross misconduct; or
- The parent – employee becomes enrolled in Medicare (Part A, Part B, or both); or
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: **Jennifer Seibert, District Benefits Manager, Peralta Community College District, 333 East 8th Street, Oakland CA 94606, (510) 466-7229**

In addition, the employee or family member must notify **Peralta Community College District** within 30 days, of the birth to or placement for adoption of a child of an individual receiving continuation coverage. The child born to or placed for adoption is also eligible for coverage. If desired, the parent who is currently a qualified beneficiary may change coverage status from individual coverage to family coverage to add the new child.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is temporary continuation coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B or both) your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation will last up to 36 months.

When the qualifying event is the end of employment or reduction of work hours, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18□month period of COBRA continuation coverage can be extended.

(Continued on next page)

Disability Extension of 18-Month Period of Continuation Coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of the COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to **Peralta Community College District.**

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when the child stops being eligible under the Plan as a dependent child.

In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to ***Peralta Community College District.***

California Only: Notice to All Terminating Employees Regarding Medi-Cal & HIV/AIDS
The California Department of Health Services will pay health insurance premiums for certain persons who are losing employment and have a high cost medical condition. In order to qualify for the Health Insurance Premium Payment (HIPP) Program, you must meet ALL of the following conditions:

- You must currently be on Medi-Cal.
- Your Medi-Cal Share of Cost, if any, must be of $200.00 or less.
- You must have an expensive medical condition. The average monthly savings to Medi-Cal from your health insurance must be at least twice the monthly insurance premiums. If you have a Medi-Cal Share of Cost, that amount will be subtracted from your monthly health care costs to determine if paying the premiums is cost effective.
- You must have a current health insurance policy, COBRA continuation policy, or a conversion policy in effect or available at the time of application.
- Your health insurance policy must cover your high cost medical condition.
- Your application must be completed and returned in time for the State of California to process your application and pay your premium.
- Your health insurance policy must not be issued through the California Major Risk Medical Insurance Board.
- You must not be enrolled in a Medi-Cal related prepaid health plan, County Health Initiative, Geographic Managed Care Program, or the county Medical Services Program (CMSP).

NOTE: If an absent parent has been ordered by the court to provide your health insurance, you will not be eligible for the HIPP Program. For more information you may call this toll free number (800) 951-5294.

Persons Disabled with HIV/AIDS
Under the Ryan White Comprehensive AIDS Resource Emergency Act of 1990 (CARE), persons unable to work because of disability due to HIV/AIDS and who are losing their private health insurance may qualify for the Health Insurance Premium Payment (CARE/HIPP) program for up to 12 months if they meet the following criteria:

- Have applied for Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), State Disability Insurance (SDI), or other disability programs;
- Are currently covered by a health insurance plan (COBRA, individual or group), which includes outpatient prescription drug coverage, and HIV related treatment services;
- Are not currently on the AIDS Drug Assistance Program (ADAP);
- Have a total monthly income of no more than 250% of the current federal poverty level and;
- Will be eligible for the Medi-Cal HIPP Program within 12 months.

For additional information on CARE/HIPP, please call the No. Cal AIDS Hotline at (800) 367-2437 (English/Spanish) or the So. Cal AIDS Hotline at (800) 922-2437 (English) and (800) 922-2438 (Multi-Language).

Special Extension Provision
Health Plans issued in California must allow individuals who have exhausted their 18-month COBRA continuation period (or 29 months, in the case of disability), to continue on the group policy for up to an additional 18 months (or an additional 7 months in the case of disability). In order to exercise the coverage continuation rights under the law, an election to purchase the extended coverage must be made in writing by the COBRA participant to the carrier, no later than 30 calendar days prior to the end of the 18-month COBRA continuation period.

If You Have Questions
If you have questions about your COBRA continuation coverage, you should contact **Jennifer Seibert, District Benefits Manager, Peralta Community College District, 333 East 8th Street, Oakland CA 94606, (510) 466-7229** or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and district EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Protected Health Information

Please review this document carefully. The privacy of your health information is important to us!

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duty, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice has been in effect since April 13, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION & EMPLOYEE RIGHTS

Access: You have the right to look at or get copies of your health information, if any exists in any offices, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00, for each page and $15.00, per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions & Complaints: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file you complaint with the U.S. Department of Health and Human Services. Contact: Privacy Officer: Jennifer Seibert 510.466.7229, Address: 333 East 8th Street, Oakland, CA 94606.

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 http://www.peralta.pswbenefits.net/ or by calling 1-510-466-7229. You may also access the Uniform Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** person/**$300** family (3 individuals) Doesn't apply to emergency room services, the prescription drug program and the following **preferred provider** services: office visits and preventive care. Copays and **coinsurance** don't count toward the **deductible**.	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**.
Are there other deductibles for specific services?	No.	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.
Is there an out-of-pocket limit on my expenses?	Yes. **Preferred Providers**: **$300** person/**$900** family (3 individuals) **Nonpreferred Providers**: **$1,000** person/**$3,000** family	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 plan for health care expenses.
What is not included in the out-of-pocket limit?	Deductible, copays, penalties for failure to pre-certify services, infertility services, premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See www.anthem.com/ca **or call 1-866-280-4120;** www.multiplan.com **or call 1-800-371-4803** for a list of participating providers.	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 don't need a referral to see a specialist.	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 4. 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 a **nonpreferred provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a **nonpreferred provider** 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 **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay	20% coinsurance	None
	Specialist visit	$10 copay	20% coinsurance	None
	Other practitioner office visit	$10 copay	20% coinsurance	None
	Preventive care/screening/immunization	No charge	Well Child Care: Not covered; Adult Preventive Care: 20% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$10 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	$15 copay for retail and $5 copay mail order/prescription		
	Non-preferred brand drugs	$15 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	20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room services	$35 copay	$35 copay	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$10 copay	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%.
	Physician/surgeon fee	No charge	20% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay	20% coinsurance	No coverage for biofeedback.
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%.
	Substance use disorder outpatient services	$10 copay	20% coinsurance	None
	Substance use disorder inpatient services	No charge	20% coinsurance	Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	None
	Delivery and all inpatient services	No charge	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Pre-certification is required. Coverage is limited to 100 visits/calendar year.
	Rehabilitation services	No charge	20% coinsurance	None
	Habilitation services	Not covered	Not covered	No coverage for habilitation services.
	Skilled nursing care	No charge	20% coinsurance	Pre-certification is required. Coverage is limited to 100 days/calendar year.
	Durable medical equipment	No charge	20% coinsurance	None
	Hospice service	No charge	20% coinsurance	Pre-certification is required.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	No coverage for eye exams under medical.
	Glasses	Not covered	Not covered	No coverage for glasses under medical.
	Dental check-up	Not covered	Not covered	No coverage for dental check-ups under medical.

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.)

- Biofeedback;
- Cosmetic surgery;
- Dental care;
- Habilitation services;
- Long-term care;
- Routine foot care;
- Weight-loss programs, and
- Well child care by a nonpreferred provider.

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 (for morbid obesity only);
- Chiropractic care;
- Hearing aids;
- Infertility treatment;
- Non-emergency care when traveling outside the U.S.;
- Private-duty nursing, and
- Routine eye care.

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 1-510-466-7229. 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 ext. 61565 or www.cciio.cms.gov.

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: 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.

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** $7,320
- **Patient pays** $220

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	$20
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,920
- **Patient pays** $480

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	$100
Copays	$300
Coinsurance	$0
Limits or exclusions	$80
Total	**$480**

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.

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 http://www.peralta.pswbenefits.net/ or by calling 1-510-466-7229. You may also access the Uniform Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** person/**$300** family (3 individuals) Doesn't apply to emergency room services, the prescription drug program and the following **preferred provider** services: office visits and preventive care. Copays and **coinsurance** don't count toward the **deductible**.	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**.
Are there other deductibles for specific services?	No.	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.
Is there an out-of-pocket limit on my expenses?	Yes. **$300** person/**$900** family (3 individuals)	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 plan for health care expenses.
What is not included in the out-of-pocket limit?	Deductible, copays, penalties for failure to pre-certify services, infertility services, premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See www.anthem.com/ca **or call 1-866-280-4120; www.multiplan.com or call 1-800-371-4803** for a list of participating providers.	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 don't need a referral to see a specialist.	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 4. 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 a **nonpreferred provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a **nonpreferred provider** 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 **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay	Not covered	None
	Specialist visit	$10 copay	Not covered	None
	Other practitioner office visit	$10 copay	Not covered	None
	Preventive care/screening/immunization	No charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$10 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	$15 copay for retail and $5 copay mail order/prescription		
	Non-preferred brand drugs	$15 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 services	$35 copay	$35 copay	Copay waived if admitted.
	Emergency medical transportation	No charge	*Not covered	*If for true emergency, plan covers 100% of customary and reasonable amount for the **covered person** from the place of **injury** or serious medical incident to the nearest **hospital** where treatment can be provided.
	Urgent care	$10 copay	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 fee	No charge	Not covered	None
If you have mental	Mental/Behavioral health outpatient services	$10 copay	Not covered	No coverage for biofeedback.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
	Mental/Behavioral health 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%.
	Substance use disorder outpatient services	$10 copay	Not covered	None
	Substance use disorder 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%.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	No charge	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Pre-certification is required. Coverage is limited to 100 visits/calendar year.
	Rehabilitation services	No charge	Not covered	None
	Habilitation services	Not covered	Not covered	No coverage for habilitation services.
	Skilled nursing care	No charge	Not covered	Pre-certification is required. Coverage is limited to 100 days/calendar year.
	Durable medical equipment	No charge	Not covered	None
	Hospice service	No charge	Not covered	Pre-certification is required.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	No coverage for eye exams under medical.
	Glasses	Not covered	Not covered	No coverage for glasses under medical.
	Dental check-up	Not covered	Not covered	No coverage for dental check-ups under medical.

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.)

- Biofeedback;
- Cosmetic surgery;
- Dental care;
- Habilitation services;
- Long-term care;
- Routine foot care;
- Weight-loss programs, and
- Well child care by a nonpreferred provider.

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 (for morbid obesity only);
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Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
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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	$20
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,920
- **Patient pays** $480

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	$100
Copays	$300
Coinsurance	$0
Limits or exclusions	$80
Total	**$480**

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.

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** person/**$300** family (3 individuals) Doesn't apply to emergency room services, the prescription drug program and the following **preferred provider** services: office visits and preventive care. Copays and **coinsurance** don't count toward the **deductible**.	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**.
Are there other deductibles for specific services?	No.	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.
Is there an out-of-pocket limit on my expenses?	Yes. **Preferred Providers**: **$300** person/**$900** family (3 individuals) **Nonpreferred Providers**: **$1,000** person/**$3,000** family	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 plan for health care expenses.
What is not included in the out-of-pocket limit?	Deductible, copays, penalties for failure to pre-certify services, infertility services, premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See www.anthem.com/ca **or call 1-866-280-4120;** www.multiplan.com **or call 1-800-371-4803** for a list of participating providers.	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 don't need a referral to see a specialist.	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 4. 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 a **nonpreferred provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a **nonpreferred provider** 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 **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	20% coinsurance	None
	Specialist visit	$15 copay	20% coinsurance	None
	Other practitioner office visit	$15 copay	20% coinsurance	None
	Preventive care/screening/immunization	No charge	Well Child Care: Not covered; Adult Preventive Care: 20% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$10 copay for retail and $20 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 $40 copay mail order/prescription		
	Non-preferred brand drugs	$20 copay for retail and $40 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	20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room services	$35 copay	$35 copay	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$15 copay	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%.
	Physician/surgeon fee	No charge	20% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay	20% coinsurance	No coverage for biofeedback.
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%.
	Substance use disorder outpatient services	$15 copay	20% coinsurance	None
	Substance use disorder inpatient services	No charge	20% coinsurance	Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	None
	Delivery and all inpatient services	No charge	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Pre-certification is required. Coverage is limited to 100 visits/calendar year.
	Rehabilitation services	No charge	20% coinsurance	None
	Habilitation services	Not covered	Not covered	No coverage for habilitation services.
	Skilled nursing care	No charge	20% coinsurance	Pre-certification is required. Coverage is limited to 100 days/calendar year.
	Durable medical equipment	No charge	20% coinsurance	None
	Hospice service	No charge	20% coinsurance	Pre-certification is required.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	No coverage for eye exams under medical.
	Glasses	Not covered	Not covered	No coverage for glasses under medical.
	Dental check-up	Not covered	Not covered	No coverage for dental check-ups under medical.

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.)**

- Biofeedback;
- Cosmetic surgery;
- Dental care;
- Habilitation services;
- Long-term care;
- Routine foot care;
- Weight-loss programs, and
- Well child care by a nonpreferred provider.

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 (for morbid obesity only);
- Chiropractic care;
- Hearing aids;
- Infertility treatment;
- Non-emergency care when traveling outside the U.S.;
- Private-duty nursing, and
- Routine eye care.

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 1-510-466-7229. 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 ext. 61565 or www.cciio.cms.gov.

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: 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.

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** $7,320
- **Patient pays** $220

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	$20
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,920
- **Patient pays** $480

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	$100
Copays	$300
Coinsurance	$0
Limits or exclusions	$80
Total	**$480**

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.

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 http://www.peralta.pswbenefits.net/ or by calling 1-510-466-7229. You may also access the Uniform Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** person/**$300** family (3 individuals) Doesn't apply to emergency room services, the prescription drug program and the following **preferred provider** services: office visits and preventive care. Copays and **coinsurance** don't count toward the **deductible**.	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**.
Are there other deductibles for specific services?	No.	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.
Is there an out-of-pocket limit on my expenses?	Yes. **$300** person/**$900** family (3 individuals)	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 plan for health care expenses.
What is not included in the out-of-pocket limit?	Deductible, copays, penalties for failure to pre-certify services, infertility services, premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See www.anthem.com/ca **or call 1-866-280-4120;** www.multiplan.com **or call 1-800-371-4803** for a list of participating providers.	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 don't need a referral to see a specialist.	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 4. 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 a **nonpreferred provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a **nonpreferred provider** 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 **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	Not covered	None
	Specialist visit	$15 copay	Not covered	None
	Other practitioner office visit	$15 copay	Not covered	None
	Preventive care/screening/immunization	No charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$10 copay for retail and $20 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 $40 copay mail order/prescription		
	Non-preferred brand drugs	$20 copay for retail and $40 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 services	$35 copay	$35 copay	Copay waived if admitted.
	Emergency medical transportation	No charge	*Not covered	*If for true emergency, plan covers 100% of customary and reasonable amount for the **covered person** from the place of **injury** or serious medical incident to the nearest **hospital** where treatment can be provided.
	Urgent care	$15 copay	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 fee	No charge	Not covered	None
If you have mental	Mental/Behavioral health outpatient services	$15 copay	Not covered	No coverage for biofeedback.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
	Mental/Behavioral health 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%.
	Substance use disorder outpatient services	$15 copay	Not covered	None
	Substance use disorder 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%.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Nonpreferred Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	No charge	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Pre-certification is required. Coverage is limited to 100 visits/calendar year.
	Rehabilitation services	No charge	Not covered	None
	Habilitation services	Not covered	Not covered	No coverage for habilitation services.
	Skilled nursing care	No charge	Not covered	Pre-certification is required. Coverage is limited to 100 days/calendar year.
	Durable medical equipment	No charge	Not covered	None
	Hospice service	No charge	Not covered	Pre-certification is required.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	No coverage for eye exams under medical.
	Glasses	Not covered	Not covered	No coverage for glasses under medical.
	Dental check-up	Not covered	Not covered	No coverage for dental check-ups under medical.

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.)

- Biofeedback;
- Cosmetic surgery;
- Dental care;
- Habilitation services;
- Long-term care;
- Routine foot care;
- Weight-loss programs, and
- Well child care by a nonpreferred provider.

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 (for morbid obesity only);
- Chiropractic care;
- Hearing aids;
- Infertility treatment;
- Non-emergency care when traveling outside the U.S.;
- Private-duty nursing, and
- Routine eye care.

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For more information on your rights to continue coverage, contact the plan at 1-510-466-7229. 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 ext. 61565 or www.cciio.cms.gov.

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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: 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.

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** $7,320
- **Patient pays** $220

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	$20
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,920
- **Patient pays** $480

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	$100
Copays	$300
Coinsurance	$0
Limits or exclusions	$80
Total	**$480**

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.

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.kp.org** or by calling **800-278-3296**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See Chart on Page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	**No**.	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.
Is there an out–of–pocket limit on my expenses?	**Yes**. **$1,500** person / **$3,000** family	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 plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, payments for health care this plan doesn't cover and cost sharing for certain services listed in plan documents.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No**.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes**. For a list of **plan providers**, see **www.kp.org** or call **800-278-3296**.	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?	**Yes**, written referral required but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	**Yes**.	Some of the services this plan doesn't cover are listed on page 4. 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 **plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 per visit	Not Covered	————————none————————
	Specialist visit	$10 per visit	Not Covered	Services related to Infertility covered at $10 per visit
	Other practitioner office visit	$10 per visit for acupuncture services.	Not Covered	Chiropractic care not covered. Physician referred acupuncture.
	Preventive care/screening/immunization	No Charge	Not Covered	Some preventive screenings (such as lab and imaging) may be at a different cost share.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	————————none————————
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	————————none————————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary.	Generic drugs	$10 per prescription for 1 to 100 day(s)	Not Covered	Certain drugs may be covered at a higher cost share.
	Preferred brand drugs	$15 per prescription for 1 to 100 day(s)	Not Covered	Certain drugs may be covered at a higher cost share.
	Non-preferred brand drugs	$15 per prescription for 1 to 100 day(s)	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	$15 per prescription for 1 to 100 day(s)	Not Covered	Same as preferred brand drugs.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 per procedure	Not Covered	——————none——————
	Physician/surgeon fees	No Charge	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services	$35 per visit	$35 per visit	——————none——————
	Emergency medical transportation	No Charge	No Charge	——————none——————
	Urgent care	$10 per visit	$10 per visit	Non plan providers covered when outside a service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	——————none——————
	Physician/surgeon fee	No Charge	Not Covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 per visit for Individual, $5 per visit for Group	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	No Charge	Not Covered	——————none——————
	Substance use disorder outpatient services	$10 per visit Individual, $5 per visit Group	Not Covered	——————none——————
	Substance use disorder inpatient services	No Charge	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	Prenatal care: No Charge, Postnatal care: No Charge	Not Covered	Cost sharing for prenatal care is for routine preventive care only. Cost sharing for postnatal care is for the first postnatal visit only.
	Delivery and all inpatient services	No Charge	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hour(s) Maximum per Visit ,Up to 100 visit(s) Maximum per Calendar Year ,Up to 3 visit(s) Maximum per Day
	Rehabilitation services	Inpatient:No Charge; Outpatient:$10 per day	Not Covered	————————none————————
	Habilitation services	$10 per day	Not Covered	————————none————————
	Skilled nursing care	No Charge	Not Covered	Up to 100 day maximum per benefit period.
	Durable medical equipment	No Charge	Not Covered	Must be in accordance with formulary guidelines
	Hospice service	No Charge	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	————————none————————
	Glasses	No Charge	Not Covered	$175 Allowance per 24 Month
	Dental check-up	Not Covered	Not Covered	————————none————————

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.)

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- Cosmetic Surgery
- Long-Term Care
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• Acupuncture with limits • Bariatric Surgery • Hearing Aids	• Infertility Treatment • Routine Eye Exam (Adult)	• Routine Foot Care • Routine Hearing Tests

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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** $7,320
- **Patient pays** $220

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	$0
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,720
- **Patient pays** $680

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	$0
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$680**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.

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.kp.org** or by calling **800-278-3296**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See Chart on Page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	**No**.	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.
Is there an out–of–pocket limit on my expenses?	**Yes**. **$1,500** person / **$3,000** family	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 plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, payments for health care this plan doesn't cover and cost sharing for certain services listed in plan documents.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No**.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes**. For a list of **plan providers**, see **www.kp.org** or call **800-278-3296**.	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?	**Yes**, written referral required but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	**Yes**.	Some of the services this plan doesn't cover are listed on page 5. 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 **plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 per visit	Not Covered	——————none——————
	Specialist visit	$15 per visit	Not Covered	Services related to Infertility covered at $15 per visit
	Other practitioner office visit	$15 per visit for acupuncture services.	Not Covered	Chiropractic care not covered. Physician referred acupuncture.
	Preventive care/screening/immunization	No Charge	Not Covered	Some preventive screenings (such as lab and imaging) may be at a different cost share.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary.	Generic drugs	Retail:$10 per prescription for 1 to 30 day(s) ; Mail Order:Usually two times the retail cost sharing for up to a 100 day supply	Not Covered	Retail: $20 per prescription for 31 to 60 day(s) ,$30 per prescription for 61 to 100 day(s).Certain drugs may be covered at a higher cost share.
	Preferred brand drugs	Retail:$20 per prescription for 1 to 30 day(s) ; Mail Order:Usually two times the retail cost sharing for up to a 100 day supply	Not Covered	Retail: $40 per prescription for 31 to 60 day(s) ,$60 per prescription for 61 to 100 day(s).Certain drugs may be covered at a higher cost share.
	Non-preferred brand drugs	$20 per prescription for 1 to 30 day(s)	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	$20 per prescription for 1 to 30 day(s)	Not Covered	Same as preferred brand drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$15 per procedure	Not Covered	——————none——————
	Physician/surgeon fees	No Charge	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services	$35 per visit	$35 per visit	——————none——————
	Emergency medical transportation	No Charge	No Charge	——————none——————
	Urgent care	$15 per visit	$15 per visit	Non plan providers covered when outside a service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	——————none——————
	Physician/surgeon fee	No Charge	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 per visit for Individual, $7 per visit for Group	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	No Charge	Not Covered	——————none——————
	Substance use disorder outpatient services	$15 per visit Individual, $5 per visit Group	Not Covered	——————none——————
	Substance use disorder inpatient services	No Charge	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	Prenatal care: No Charge, Postnatal care: No Charge	Not Covered	Cost sharing for prenatal care is for routine preventive care only. Cost sharing for postnatal care is for the first postnatal visit only.
	Delivery and all inpatient services	No Charge	Not Covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hour(s) Maximum per Visit ,Up to 100 visit(s) Maximum per Calendar Year ,Up to 3 visit(s) Maximum per Day
	Rehabilitation services	Inpatient:No Charge; Outpatient:$15 per day	Not Covered	——————none——————
	Habilitation services	$15 per day	Not Covered	——————none——————
	Skilled nursing care	No Charge	Not Covered	Up to 100 day maximum per benefit period.
	Durable medical equipment	No Charge	Not Covered	Must be in accordance with formulary guidelines
	Hospice service	No Charge	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	——————none——————
	Glasses	No Charge	Not Covered	$175 Allowance per 24 Month
	Dental check-up	Not Covered	Not Covered	——————none——————

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