The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, web.peralta.edu/benefits. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-510-466-7229 to request a copy.

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

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Penalties for failure to pre-certify services, drug copays from non-participating pharmacies, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca **or call 1-866-280-4120** for a list of preferred providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit (Deductible does not apply)	20% coinsurance	None
	Specialist visit	$10 copay/visit (Deductible does not apply)	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. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	None
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 (Deductible does not apply) for retail and $5 copay (Deductible does not apply) 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 (Deductible does not apply) for retail and $5 copay (Deductible does not apply) mail order/prescription		
	Non-preferred brand drugs	$15 copay (Deductible does not apply) for retail and $5 copay (Deductible does not apply) 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)	0% coinsurance	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Emergency: $35 copay/visit (Deductible does not apply) Non-Emergency: $35 copay/visit then 20% coinsurance	Preferred provider benefit applies	Copay waived of admitted.
	Emergency medical transportation	No charge	Preferred provider benefit applies	None
	Urgent care	$10 copay/visit (Deductible does not apply)	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit (Deductible does not apply)	20% coinsurance	No coverage for biofeedback.
	Inpatient services	0% coinsurance	20% coinsurance	Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%.
If you are pregnant	Office visits	$10 copay/initial visit; (Deductible does not apply)	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (*i.e.*, ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Coverage is limited to 100 visits/calendar year.
	Rehabilitation services	0% coinsurance	20% coinsurance	None
	Habilitation services	0% coinsurance	20% coinsurance	Coverage is limited to attention deficit disorders.
	Skilled nursing care	0% coinsurance	20% coinsurance	Coverage is limited to 100 days/calendar year.
	Durable medical equipment	0% coinsurance	20% coinsurance	None
	Hospice services	0% coinsurance	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for eye exams under medical.
	Children's glasses	Not covered	Not covered	No coverage for glasses under medical.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups under medical.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- 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: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Peralta Community College District at 1-510-466-7229 or visit us at www.myTrustmarkBenefits.com.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-510-466-7229.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-510-466-7229.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-510-466-7229.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-510-466-7229.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$100
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$170**

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

The plan's overall deductible	$100
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$320**

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

The plan's overall deductible	$100
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$170**

The plan would be responsible for the other costs of these EXAMPLE covered services.