




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

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

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /visit ( <a href="#">Deductible</a> does not apply)	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$15 <a href="#">copay</a> /visit ( <a href="#">Deductible</a> does not apply)	20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	<u>Well Child Care:</u> Not covered <u>Adult Preventive Care:</u> 20% <a href="#">coinsurance</a>	Coverage is limited to 1 mammogram/calendar year age 35 & over, 1 gyn exam & pap smear/calendar year and 1 PSA test/calendar year age 40 & over. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> ..	Generic drugs	\$10 <a href="#">copay</a> ( <a href="#">Deductible</a> does not apply) for retail and \$20 <a href="#">copay</a> ( <a href="#">Deductible</a> 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	\$20 <a href="#">copay</a> ( <a href="#">Deductible</a> does not apply) for retail and \$30 <a href="#">copay</a> ( <a href="#">Deductible</a> does not apply) mail order/prescription		
	Non-preferred brand drugs	\$20 <a href="#">copay</a> ( <a href="#">Deductible</a> does not apply) for retail and \$30 <a href="#">copay</a> ( <a href="#">Deductible</a> does not apply) mail order/prescription		
	<a href="#">Specialty drugs</a>	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% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	Emergency: \$35 <a href="#">copay</a> /visit ( <a href="#">Deductible</a> does not apply) Non-Emergency: \$35 <a href="#">copay</a> /visit then 20% <a href="#">coinsurance</a>	<a href="#">Preferred provider</a> benefit applies	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	No charge	<a href="#">Preferred provider</a> benefit applies	None
	<a href="#">Urgent care</a>	\$15 <a href="#">copay</a> /visit ( <a href="#">Deductible</a> does not apply)	20% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <a href="#">copay</a> /visit ( <a href="#">Deductible</a> does not apply)	20% <a href="#">coinsurance</a>	No coverage for biofeedback.
	Inpatient services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Pre-certification is required. If the covered person fails to pre-certify services, covered expenses will be reduced by 25%.
If you are pregnant	Office visits	\$15 <a href="#">copay</a> /initial visit ( <a href="#">Deductible</a> does not apply)	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copay</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC ( <i>i.e.</i> , ultrasound.)
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Coverage is limited to 100 visits/calendar year.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Coverage is limited to attention deficit disorders.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Coverage is limited to 100 days/calendar year.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Biofeedback therapy;</li> <li>Cosmetic surgery;</li> </ul>	<ul style="list-style-type: none"> <li>Dental care;</li> <li>Long-term care;</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care;</li> <li>Weight-loss programs, and</li> <li>Well child care by a <a href="#">nonpreferred provider</a>.</li> </ul>

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

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

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

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information 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.myT rustmarkBenefits.com](http://www.myT rustmarkBenefits.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, kwijigo holne' 1-510-466-7229.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



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

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

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

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$170</b>

### Managing Joe's Type 2 Diabetes

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

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

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$320</b>

### Mia's Simple Fracture

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

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

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$90
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$190</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.