

# Your summary of benefits



Anthem® Blue Cross

Your Plan: Contra Costa Community College District: CUSTOM EPO E5 (0/20/0)

Your Network: Prudent Buyer PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	\$10 copay per visit
Mental Health & Substance Use Disorder Services	\$10 copay per visit
Specialist care	\$20 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Overall Deductible	\$0 person
Overall Out-of-Pocket Limit	\$1,500 person / \$4,500 family

To get benefits under this Plan, you must use In-Network Providers. Services from Out-of-Network Providers are not covered, except for Emergency Care, Authorized Services, prescription drugs at a retail pharmacy, or when required by law. Please be sure to contact us if you are not sure if we have approved an Authorized Service.

The family out-of-pocket limit is embedded, meaning each covered person is capped at his or her per person out-of-pocket limit; in addition, cost shares for all covered family members apply to the family out-of-pocket limit, yet no one member will pay more than the per person out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.

Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*

Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$20 copay per visit
--	----------------------

Specialist Care <i>virtual and office</i>	\$20 copay per visit
---	----------------------

## Other Practitioner Visits

Maternity services Prenatal and Postnatal care	\$20 copay per visit
---	----------------------

Delivery	No charge
----------	-----------

Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$20 copay per visit
---	----------------------

Manipulation Therapy <i>Coverage is limited to 24 visits per benefit period.</i>	No charge
---	-----------

Covered Medical Benefits	Cost if you use an In-Network Provider
Acupuncture <i>Coverage is limited to 30 visits per benefit period.</i>	No charge
<u>Other Services in an Office</u> Allergy Testing  Prescription Drugs <i>Dispensed in the office</i>  Surgery	No charge  No charge  No charge
Preventive care / screenings / immunizations	No charge
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge
<u>Diagnostic Services</u> Lab Office  Freestanding Lab  Outpatient Hospital	No charge  No charge  No charge
X-Ray Office  Freestanding Radiology Center  Outpatient Hospital	No charge  No charge  No charge
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i>  Office  Freestanding Radiology Center  Outpatient Hospital	No charge  No charge  No charge
<u>Emergency and Urgent Care</u> <i>Urgent Care includes doctor services. Additional charges may apply depending on the care provided.</i>  Emergency Room Facility Services <i>Your copay will be waived if admitted.</i> Emergency Room Doctor and Other Services  Ambulance	\$20 copay per visit  In-Network and Out-of-Network Providers: \$50 copay per visit  In-Network and Out-of-Network Providers: No charge  No charge

Covered Medical Benefits	Cost if you use an In-Network Provider
Outpatient Mental Health and Substance Use Disorder Services at a Facility	
Facility Fees	No charge
Doctor Services	No charge
<u>Outpatient Surgery</u>	
Facility Fees	
Hospital	No charge
Ambulatory Surgical Center	No charge
Physician and other services <i>including surgeon fees</i>	
Hospital	No charge
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u>	
Facility Fees	No charge
Physician and other services <i>including surgeon fees</i>	No charge
Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	No charge
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 24 visits combined per benefit period.</i>	
Office	No charge
Outpatient Hospital	No charge
Pulmonary rehabilitation <i>office and outpatient hospital</i>	No charge
Cardiac rehabilitation <i>office and outpatient hospital</i>	No charge
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	No charge
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	No charge
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	No charge
Inpatient Hospice	No charge
Durable Medical Equipment	20% coinsurance

Covered Medical Benefits		Cost if you use an In-Network Provider	
Prosthetic Devices		No charge	

  

Covered Prescription Drug Benefits		Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible		Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit		Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>CA National DMHC If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>			
Day Supply Limits: Retail Pharmacy <i>30 day supply (cost shares noted below)</i> Retail 90 Pharmacy <i>90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</i> Home Delivery Pharmacy <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.</i> Specialty Pharmacy <i>30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.</i>			
Tier 1 - Typically Generic		\$10 copay per prescription (retail and home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand		\$20 copay per prescription (retail and home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand		\$20 copay per prescription (retail and home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)		\$20 copay per prescription (retail and home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)

Notes:

- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".

- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- The representations of benefits in this document are subject to California Department of Managed Health Care (DMHC) approval and are subject to change.

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Questions: (855) 333-5730 or visit us at [www.anthem.com/ca](http://www.anthem.com/ca)

Intentionally Left Blank

## Get help in your language

### Language Assistance Services

Curious to know what all this says?

We would be too. Here's the English version:  
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

#### Spanish

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

#### Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضاً من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

#### Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

#### Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

#### Farsi

ما، توانیدمی اگر بخوانید؟ را نامه این توانید می آیا مهم. کند کمک شما به آن خواندن در بخواهیم شخصی از توانیممی زبان به و کتبی صورت به را نامه این بتوانید است ممکن همچنین با فوراً لطفاً، رایگان کمک دریافت برای. کنید دریافت خودتان تماس (TTY/TDD: 711) 1-888-254-2721. شماره بگیرید.

#### Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

#### Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

#### Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721 (TTY/TDD:711) にご連絡ください。

#### Khmner

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសា របស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយ ឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)



**Korean**

중요: 이 편지를 읽으실 수 있으신가요?  
 그렇지 않으신 경우, 이를 읽으실 수 있도록  
 도움을 제공해 드릴 수 있습니다. 귀하의  
 모국어로 된 편지를 우편으로 받아보실 수도  
 있습니다. 무상으로 제공되는 도움이  
 필요하신 경우, 1-888-254-2721번으로 바로  
 연락해 주십시오. (TTY/TDD: 711)

**Punjabi**

ਕੀ ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ  
 ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ  
 ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ।  
 ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ  
 ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

**Russian**

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли  
 вы прочитать данное письмо? Если нет,  
 наш специалист поможет вам в этом.  
 Вы также можете получить данное  
 письмо на вашем языке. Для получения  
 бесплатной помощи звоните по номеру  
 1-888-254-2721. (TTY/TDD: 711)

**Tagalog**

MAHALAGA: Mababasa mo ba ang  
 sulat na ito? Kung hindi, mayroon kaming  
 makakatulong sa iyo na basahin ito.  
 Maaari mo ring makuha ang sulat na ito  
 nang nakasulat sa iyong wika. Para sa  
 libreng tulong, mangyaring tumawag  
 kaagad sa 1-888-254-2721.  
 (TTY/TDD: 711)

**Thai**

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่  
 หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้  
 ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอ  
 จดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน  
 หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย  
 โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721.  
 (TTY/TDD: 711)

**Vietnamese**

QUAN TRỌNG: Quý vị có đọc được lá thư  
 này không? Nếu không, chúng tôi có thể  
 nhờ ai đó giúp quý vị đọc. Quý vị cũng có  
 thể yêu cầu thư này viết bằng ngôn ngữ  
 của quý vị. Để được trợ giúp miễn phí,  
 hãy gọi ngay đến số 1-888-254-2721.  
 (TTY/TDD: 711)

**It's important we treat you fairly**

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>