Your summary of benefits

Anthem BlueCross

Anthem Blue Cross ACWA JPIA – C00361

Your Plan: 2021 HMO Plan (1VYT) -Medical benefits only plan for Retirees with Medicare A&B

Your Network: California Care HMO

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 HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$0	N/A
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$500 single / $1,500 family	N/A
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Primary care visit to treat an injury or illness	$10 copay per visit	Not covered
Specialist care visit	$10 copay per visit	Not covered
Prenatal and Post-natal Care	$10 copay per visit	Not covered
Other practitioner visits:		
Retail health clinic	$10 copay per visit	Not covered
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse.*	No charge	Not covered

Your summary of benefits

Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Chiropractor services *Coverage for In-Network Provider is limited to 60 visits per illness or injury. Limit is combined with Physical Therapy, Physical Medicine, and Occupational Therapy. Physician referral is required.*	$10 copay per visit	Not covered
Chiropractic care benefits also available through the American Specialty Health Plans Chiropractic network. Limited to 30 visits per year. Appliances limited to $50 per year. Physician referral is not required.	$10 copay per visit	Not covered
Acupuncture	$10 copay per visit	Not covered
Other services in an office:		
Allergy testing	$10 copay per visit	Not covered
Chemo/radiation therapy	$10 copay per visit	Not covered
Hemodialysis	$10 copay per visit	Not covered
Prescription drugs *For the drug itself, dispensed in an office through infusion/injection*	20% coinsurance up to $100 per visit	Not covered
Diagnostic Services		
Lab:		
Office	No charge	Not covered
Freestanding Lab	No charge	Not covered
Outpatient Hospital	No charge	Not covered
X-ray:		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	No charge	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	No charge	Not covered

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Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Emergency and Urgent Care		
Emergency room facility services *This is for the hospital/facility charge only.* *Copay waived if admitted.*	$50 copay per visit	Covered as In-Network
Emergency room doctor and other services	No charge	Covered as In-Network
Ambulance (air and ground)	$50 copay per trip for ground and air	Covered as In-Network
Urgent Care (office setting)	$10 copay per visit	(Out of service area) Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$10 copay per visit	Not covered
Facility visit:		
Facility fees	No charge	Not covered
Outpatient Surgery		
Facility fees:		
Hospital	No charge	Not covered
Freestanding Surgical Center	No charge	Not covered
Doctor and other services	No charge	Not covered
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	No charge	Not covered
Doctor and other services	No charge	Not covered
Recovery & Rehabilitation		
Home health care	No charge	Not covered

Your summary of benefits

Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for In-Network Provider is limited to 60 consecutive days per illness or injury for Physical, Occupational and Speech Therapy combined. Limit is combined with 60 Chiropractic visit limit.*	$10 copay per visit	Not covered
Outpatient hospital *Coverage for In-Network Provider is limited to 60 consecutive days per illness or injury for Physical, Occupational and Speech Therapy combined. Limit is combined with 60 Chiropractic visit limit.*	No charge	Not covered
Habilitation services *Habilitation and Rehabilitation visits count towards your Rehabilitation limit.*		
Office	$10 copay per visit	Not covered
Outpatient hospital	No charge	Not covered
Cardiac rehabilitation		
Office	$10 copay per visit	Not covered
Outpatient hospital	No charge	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Provider is limited to 100 day limit per benefit period.*	No charge	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment	No charge	Not covered
Prosthetic Devices	No charge	Not covered

Your summary of benefits

Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- Your plan requires a selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to five consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Infertility services are not included in the out of pocket amount.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_HMO

VibrantRx (PDP)™

2021 Summary of Benefits

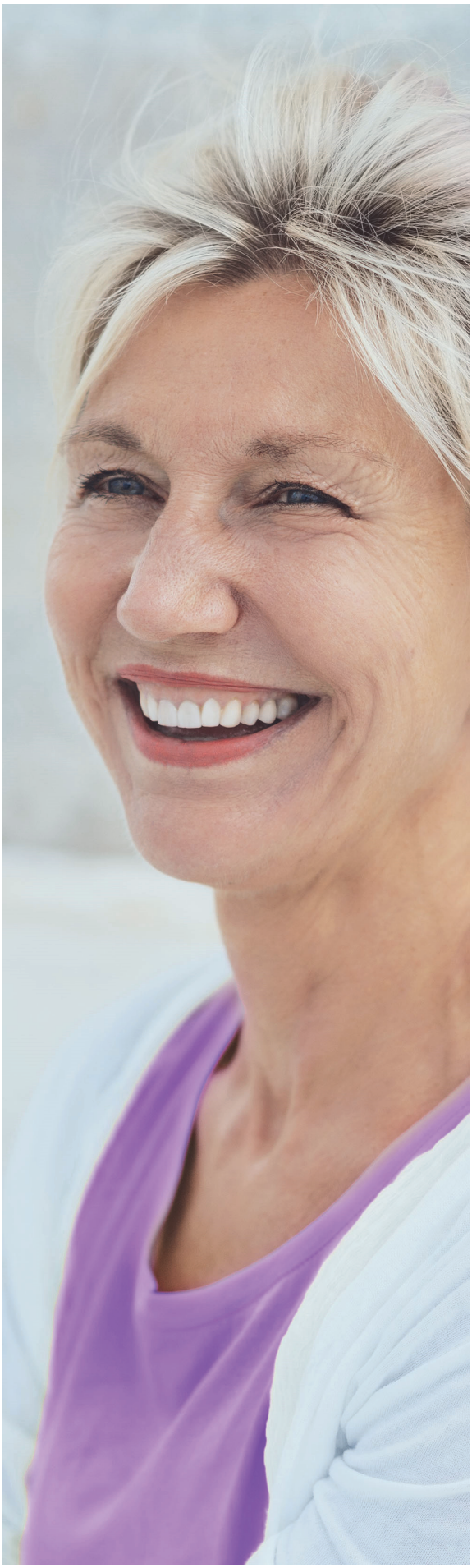
for ACWA JPIA Medicare-eligible retirees enrolled in an Anthem plan

January 1, 2021 - December 31, 2021

This is a summary of prescription drug services covered by VibrantRx (PDP) and what you pay.

VibrantRx is a Prescription Drug Plan with a Medicare contract offered by MG Insurance Company. Enrollment in VibrantRx depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."



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www.MyVibrantRx.com/JPIA

Who Can Join This Plan?
To join VibrantRx, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, be eligible for these benefits from your employer group health plan and live in our service area. Our service area includes all 50 states and the District of Columbia.

Which Pharmacies Can I Use?
VibrantRx has a network of pharmacies and you must generally use these pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's pharmacy directory on our web site (www.MyVibrantRx.com/JPIA). Or, call us and we will send you a copy of the pharmacy directory.

Which Drugs are Covered?

We cover Part D drugs. Your employer group also covers prescription drugs not normally covered in a Medicare Prescription Drug Plan. These include:

- Cough and Cold
- Drug Efficacy Study Implementation (DESI) drugs
- Vitamins and Minerals
- Lifestyle Drugs
- Erectile Dysfunction (ED) Drugs
- Contraceptive Devices
- Fertility Drugs

Drugs that are excluded from Part D coverage do not count towards your True-Out-of-Pocket expenses. You will continue to pay the applicable tier cost share for these drugs if you reach the Catastrophic stage of your benefit. Drugs excluded from Part D coverage but covered by your employer group's supplemental benefit are marked as "EX" in your formulary. For a complete plan formulary (list of prescription drugs covered by the plan), please call Member Services. You can also see the complete plan formulary and any restrictions on our web site: (www.MyVibrantRx.com/JPIA)

Tips for Comparing Medicare Choices
If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document may be available in other formats such as braille or large print.

Premiums and Benefits	VibrantRx (PDP)	What you should know
Monthly Part D Plan Premium	Your coverage is provided through a contract with your employer and ACWA JPIA. In most cases, the cost of this coverage is included in the premium for the Anthem plan in which you are enrolled. However, plan participants with income above or below thresholds set by CMS may require additional payment (deducted by Social Security) or receive premium offset credits. Also, those with a late enrollment penalty will be responsible for that additional cost. Visit www.cms.gov for more information. You may also contact the ACWA JPIA Benefits department toll free at 1-800-736-2292 for additional information about your plan premium. Hours are Monday through Friday, 7:30am - 4:30pm, Pacific time.	You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.	

Part D Prescription Drugs

Your cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy- specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.

Initial Coverage:
During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach $6,550. Additionally, once your out-of-pocket costs for covered Mail Order prescriptions, except covered ED drugs, reach $1000 out-of-pocket maximum, you will no longer pay a copayment for those drugs at Mail Order for the rest of the plan year.

	Standard Retail Pharmacy (30-day supply)	Standard Retail Pharmacy (90-day supply)	Mail Order Pharmacy (90-day supply)
Tier 1: Generic	$5 copayment	$10 copayment	$10 copayment
Tier 2: Preferred Brand	$20 copayment	$40 copayment	$40 copayment
Tier 3: Non-Preferred Brand	$50 copayment	$100 copayment	$100 copayment
Tier 4: Specialty	$50 copayment	Long term supply is not available for drugs in Tier 4	Long term supply is not available for drugs in Tier 4
Tier 5: Select Care*	$0 copayment	$0 copayment	$0 copayment

*Select generics are available at $0 copay. Your employer group also covers prescription drugs not normally covered in a Medicare Prescription Drug Plan. Drugs that are excluded from Part D coverage do not count towards your True-Out-of-Pocket expenses. You will continue to pay the applicable tier cost share for these drugs if you reach the Catastrophic stage of your benefit. Drugs excluded from Part D coverage but covered by ACWA JPIA's supplemental benefit are marked as "EX" in your formulary. See your formulary for details. You pay the copayments above for these drugs, including:

- Cough and Cold, Drug Efficacy Study Implementation (DESI) drugs, Vitamins and Minerals, Lifestyle Drugs
- Erectile Dysfunction (ED) Drugs **(you pay 50% coinsurance – limited to 6 pills per 30 days)**
- Contraceptive Devices **(you pay $20 copayment per covered device)**
- Fertility Drugs **(you pay $50 copayment per 30-day supply)**

Coverage Gap:
Because there is no Coverage Gap (also called the "donut hole") for the plan, this payment stage does not apply to you. You will continue to pay the same cost sharing amounts for your drugs as you paid in the Initial Coverage stage until you qualify for the Catastrophic Coverage Stage.

Catastrophic Coverage:
If you haven't met your $1,000 Mail Order out-of-pocket maximum, after your yearly out-of-pocket drug costs reach $6,550 for Part D drugs, you pay:

- Tier 1: 5% of the cost with a minimum copayment of $3.70 and a maximum copayment of $5
- Tier 2-4: 5% of the cost with a minimum copayment of $9.20 and a maximum copayment of $20
- Tier 5: $0

For drugs offered under your employer group's enhanced benefit (excluded from Part D), you will continue to pay the applicable tier copayment or coinsurance during the Catastrophic Coverage Stage.

VibrantRx (PDP)

Member Services: 1-844-826-3451. (TTY only, call 711)
24 hours a day, 365 days a year

www.MyVibrantRx.com/JPIA

vibrantrx.
prescription drug plan