Your summary of benefits

ACWA JPIA C00361

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: 2025 Consumer Driven Health Plan (CDHP) (EV85) (1DMW)

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	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$1,650 person / $3,300 family	$1,650 person / $3,300 family
Overall Out-of-Pocket Limit	$2,500 person / $4,000 family	$2,500 person / $4,000 family
The family deductible and out-of-pocket limit are non-embedded, meaning the cost shares of all family members apply to one family deductible and one family out-of-pocket limit. The per person deductible and per person out-of-pocket limit apply to individuals enrolled under single-only coverage. All deductibles, copayments and coinsurance apply to the out-of-pocket limit. In-Network and Out-of-Network deductibles are combined and accumulate toward each other; however In-Network and Out-of-Network out-of-pocket limit amounts accumulate separately and do not accumulate toward each other.		
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 *virtual and office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care *virtual and office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Manipulation Therapy (Chiropractic Services) *Coverage for rehabilitative and habilitative physical therapy, occupational therapy and manipulative treatment is limited to 30 visits combined per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Acupuncture *Coverage is limited to 12 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office* *Maximum of $250 member cost share per drug.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after deductible is met
<u>Diagnostic Services</u>		
Lab		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Lab *Coverage for Out-of-Network Provider is limited to $350 maximum per visit*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center *Coverage for Out-of-Network Provider is limited to $350 maximum per visit*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Freestanding Radiology Center *Coverage for Out-of-Network Provider is limited to $800 maximum per test*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $800 maximum per test*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$100 copay per visit and 20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center *Coverage for Out-of-Network Provider is limited to $350 maximum per visit*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) *Member is responsible for an additional $500 copay if prior authorization is not obtained from Anthem for non-emergency Inpatient admissions to Out-of-Network Providers. Anthem's maximum payment is up to $600 per day for non-emergency Inpatient admissions to Out-of-Network Providers.*		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and manipulative treatment is limited to 30 visits combined per benefit period.*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 100 days per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hearing Aids *Coverage is limited to 1 item per ear every 3 years.*	20% coinsurance after medical deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with medical deductible.	Combined with medical deductible.
Pharmacy Out-of-Pocket Limit	Combined with medical out of pocket.	Combined with medical out of pocket.
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National*** *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.* **Preferred Generics:** *If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed. This does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Home Delivery Pharmacy** *90-day supply (maximum cost shares noted below) of medications are available through CarelonRx Mail for 2 X the retail copay. You will need to call us on the number on your ID card to sign up when you first use the service. Please note that* ***maintenance*** *medications are subject to mandatory home delivery services through CarelonRx Mail after two retail fills have been dispensed at a retail pharmacy. Maintenance medications may also be filled at Walmart, Costco, Sam's Club, Albertsons, Vons, Pavilions, Safeway, and Ralphs at a 90-day supply for 2 X the retail copay.* **Specialty Pharmacy** *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.*		
Preventive Drugs *No deductible, copayment or coinsurance applies to prescription drugs on the PreventiveRX Plus drug list when you use an In-Network Pharmacy.* *Certain drugs on the Preventive Rx Plus list may be purchased at the applicable tier copay without being subject to the plan deductible. Visit* www.anthem.com/CA *for more information.*		
Tier 1 - Typically Generic	$5 copay per prescription (retail) and $10 copay per prescription (home delivery)	$5 copay + 50% coinsurance up to $250 per prescription (retail only), plus costs in excess of the max allowed amount
Tier 2 - Typically Preferred Brand	$20 copay per prescription (retail) and $40 copay per	$20 copay + 50% coinsurance up to $250 per prescription (retail

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	prescription (home delivery)	only), plus costs in excess of the max allowed amount
Tier 3 - Typically Non-Preferred Brand	$50 copay per prescription (retail) and $100 copay per prescription (home delivery)	$50 copay + 50% coinsurance up to $250 per prescription (retail only), plus costs in excess of the maximum allowed amount
Tier 4 - Typically Specialty (brand and generic)	$5 copay per prescription (Generic Specialty) 20% coinsurance up to $100 per prescription (Brand Specialty)	Not covered

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

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.
- Outpatient Facility tests and treatments are limited to $350 per admission for Out-of-Network Providers. Includes: Diagnostic Services; X-ray; Surgery; Rehabilitation; Habilitation; Cardiac Therapy; Surgery at Ambulatory Surgical Centers.
- Advanced Diagnostic Imaging is limited to $800 per service for Out-of-Network Providers.
- 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.

- Additional family building and fertility benefits are available through Progyny. Call Progyny at 866-461-4990 to learn more.
- Certain surgeries, including knee replacement, hip replacement, lumbar fusion, cardiac bypass, and bariatric surgery, may be covered at no cost through Carrum Health. Call 1-888-855-7806 or visit my.carrumhealth.com/acwajpia to learn more.
- Hinge Health is a virtual physical therapy benefit in addition to this plan's physical therapy benefits. To learn more, go to www.hingehealth.com/acwajpia.
- Certain drugs on the Preventive Rx Plus Drug List may be purchased at the applicable tier copay without being subject to the plan deductible.
- When using a non-network pharmacy; members are responsible for the in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount up to $250 per prescription, and costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Preferred Generics: If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed. This does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.
- Certain drugs require pre-authorization approval to obtain coverage.
- Supply limits for certain drugs may be different
- Maintenance medications are subject to mandatory home delivery services after two retail fills have been dispensed at a retail pharmacy. Maintenance medications may also be filled at Walmart, Costco, Sam's Club, Albertsons, Vons, Pavilions, Safeway and Ralphs. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.
- For additional information on this plan, please visit www.acwajpia.com/member-agency-benefits to obtain a Summary of Benefit Coverage or Evidence of Coverage.

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.

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

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It's important we treat you fairly

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