

# Your summary of benefits



ACWA JPIA – C00361

Anthem® Blue Cross

Your Plan: 2022 Consumer Driven Health Plan (CDHP) (EV85) (1DMW)

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$1,500 person / \$3,000 family	\$1,500 person / \$3,000 family
<b>Out-of-Pocket Limit</b>	\$2,500 person / \$4,000 family	\$2,500 person / \$4,000 family
<p>The family deductible and out-of-pocket maximum are non-embedded, meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The per person deductible and per person out-of-pocket maximum only apply to individuals enrolled under single coverage.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles are combined and accumulate toward each other; however, in-network and out-of-network out-of-pocket maximum amounts accumulate separately and do not accumulate toward each other.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	40% coinsurance after deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	40% coinsurance after deductible is met
<b><u>Visits in an Office</u></b>		
<b>Primary Care (PCP)</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Specialist Care</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Virtual Visits from Online Provider LiveHealth Online</b> <i>via</i> <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> ; <i>our mobile app, website or Anthem-enabled device</i>  Primary Care (PCP) and Mental Health and Substance Use Disorder	0% coinsurance after deductible is met	

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p> <p><b>Retail Health Clinic</b></p> <p><b>Manipulation Therapy (Chiropractic Services)</b>  <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits per calendar year for Physical Therapy, Physical Medicine, Occupational Therapy, and Chiropractor Services. Additional visits may be authorized.</i></p> <p><b>Acupuncture</b>  <i>Coverage is limited to 12 visits per calendar year.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Chemo/Radiation Therapy</b></p> <p><b>Dialysis/Hemodialysis</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i>  <i>Maximum of \$250 member cost share per drug.</i></p> <p><b>Surgery</b></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Freestanding Lab  <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit</i></p> <p>Outpatient Hospital  <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>X-Ray</b></p> <p>Office</p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Radiology Center <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit</i> Outpatient Hospital <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit</i>	20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>  Office  Freestanding Radiology Center <i>Coverage for Out-of-Network Provider is limited to \$800 maximum per test.</i> Outpatient Hospital <i>Coverage for Out-of-Network Provider is limited to \$800 maximum per test.</i>	20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b><u>Emergency and Urgent Care</u></b> <b>Urgent Care</b>  <b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i>  <b>Emergency Room Doctor and Other Services</b>  <b>Ambulance</b>	20% coinsurance after deductible is met  \$100 copay per visit and then 20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  Covered as In-Network  Covered as In-Network  Covered as In-Network
<b><u>Outpatient Mental Health and Substance Use Disorder</u></b> <b>Doctor Office Visit</b>  <b>Facility Visit</b> Facility Fees  Doctor Services	20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b><u>Outpatient Surgery</u></b> <b>Facility Fees</b> Hospital <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit</i>	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 a Non-Network Provider
<p>Freestanding Surgical Center <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit</i></p> <p><b>Doctor and Other Services</b></p> <p>Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u></b> <i>Member is responsible for an additional \$500 copay if prior authorization is not obtained from Anthem for non-emergency Inpatient admissions to non-network providers. Anthem's maximum payment is up to \$600 per day for non-emergency Inpatient admissions to non-network providers.</i></p> <p><b>Facility Fees</b></p> <p><b>Doctor and other services</b></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b> <i>Coverage is limited to 100 visits per calendar year.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Rehabilitation services</b> <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits per calendar year for Physical Therapy, Physical Medicine, Occupational Therapy, and Chiropractor Services. Additional visits may be authorized.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b> <i>Coverage is limited to 100 days per calendar year.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Inpatient Hospice</b>	20% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Durable Medical Equipment</b> <i>Hearing aids benefit limited to 1 per ear every 3 years (digital hearing aids are included).</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Prosthetic Devices</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

# Your summary of benefits



Covered Prescription Drug Benefits	Your cost if you use an In-Network Pharmacy	Your cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Combined with medical deductible	Combined with medical deductible
<b>Pharmacy Out of Pocket</b>	Combined with medical Out of Pocket	Combined with medical Out of Pocket
<p><b>Prescription Drug Coverage</b>  <i>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, or Sam's Club. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.</i>  <i>Certain drugs on the MedImpact Safe Harbor Drug List may be purchased at the applicable tier copay without being subject to the plan deductible. Visit <a href="http://www.medimpact.com/jpia">www.medimpact.com/jpia</a> for more information.</i></p>		
<p><b>Preventive Pharmacy</b></p> <p>ACA preventive drugs</p>	\$0 copay	50% coinsurance up to \$250 per prescription (retail only), plus costs in excess of the maximum allowed amount
<p><b>Generic Drugs</b>  <i>Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)</i></p>	\$5 copay per prescription (retail only) and \$10 copay per prescription (home delivery only)	\$5 copay + 50% coinsurance up to \$250 per prescription (retail only), plus costs in excess of the maximum allowed amount

# Your summary of benefits

Covered Prescription Drug Benefits	Your cost if you use an In-Network Pharmacy	Your cost if you use a Non-Network Pharmacy
<p><b>Brand Name Formulary Drugs</b>  <i>Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)</i></p>	<p>\$20 copay per prescription (retail only) and \$40 copay per prescription (home delivery only)</p>	<p>\$20 copay + 50% coinsurance up to \$250 per prescription (retail only), plus costs in excess of the maximum allowed amount</p>
<p><b>Brand Name Non-Formulary Drugs</b>  <i>Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)</i></p>	<p>\$50 copay per prescription (retail only) and \$100 copay per prescription (home delivery only)</p>	<p>\$50 copay + 50% coinsurance up to \$250 per prescription (retail only), plus costs in excess of the maximum allowed amount</p>
<p><b>Specialty Drugs</b>  <i>Covers up to a 30 day supply. Specialty home delivery program required.</i></p>	<p>Generic Specialty: \$5 copay per prescription            Brand Specialty: 20% coinsurance up to \$100 per prescription</p>	<p>Not Covered</p>

## Notes:

- If you have an office visit with your Primary Care Physician or Specialist 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.
- Outpatient Facility tests and treatments are limited to \$350 per visit for Non-Network Providers. Includes Diagnostic Services, X-ray, Surgery, Rehabilitation, Habilitation, and Cardiac Therapy. This also includes Surgery at Freestanding Facilities. Advanced Diagnostic Imaging is limited to \$800 per service for Non-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.
- 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](http://my.carrumhealth.com/acwajpia) to learn more.
- When using 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, or Sam's Club. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.
- For prescription drug coverage information on this plan, please call 1-888-728-5056 or visit [www.medimpact.com/jpia](http://www.medimpact.com/jpia)
- CDHP: Certain drugs on the MedImpact Safe Harbor Drug List may be purchased at the applicable tier copay without being subject to the plan deductible.
- For additional information on this plan, please visit [www.acwajpia.com/member-agency-benefits](http://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.*



# 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 alternate 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? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

### Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD: 711).

### Armenian

ՌԻՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

### Chinese

**重要事項:** 您能看懂這封信函嗎? 如果您看不懂, 我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助, 請立即撥打1-888-254-2721。(TTY/TDD: 711)

### Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

### Hindi

**महत्वपूर्ण:** क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

### Hmong

**TSEEM CEEB:** Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

### Japanese

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重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。  
1-888-254-2721 (TTY/TDD: 711)

**Khmer**  
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចជួយអ្នកក្នុងការអានលិខិតនេះដោយសេរីដោយសេរីដោយសេរីដោយសេរីដោយសេរី។ ដើម្បីទទួលបានជំនួយភ្នាក់ងារ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

**Korean**  
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

**Punjabi**  
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਕੇ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੱਖੀ ਪੜ੍ਹ ਪਾ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ।  
(TTY/TDD: 711)

**Russian**  
ВАЖНО. 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: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

**Thai**  
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังสามารถให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

**Vietnamese**  
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

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

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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