Your summary of benefits

ACWA JPIA - C00361

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: 2027 Classic PPO Plan (1122) (Z0JZ)

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 deductible does not apply
Mental Health & Substance Use Disorder Services	No charge deductible does not apply
Specialist care	$15 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$200 person / $600 family	$200 person / $600 family
Overall Out-of-Pocket Limit *The out-of-pocket costs you pay for prescription drugs obtained at a pharmacy will apply to a separate Pharmacy Out-of-Pocket Limit. See the Covered Prescription Drug Benefits section.*	$2,000 person / $4,000 family	$2,000 person
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical deductibles, copayments and coinsurance apply to the medical 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) *virtual and office*	$15 copay per visit deductible does not apply	20% coinsurance after deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	$15 copay per visit deductible does not apply	20% coinsurance after deductible is met
Specialist Provider *virtual and office*	$15 copay per visit deductible does not apply	20% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	20% coinsurance after deductible is met	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
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$15 copay per visit deductible does not apply	20% coinsurance after deductible is met
Manipulation Therapy *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	20% 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
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	20% 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	20% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	20% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Cost share is based on the setting services are received.
Diagnostic Services Lab		
Office	20% coinsurance after deductible is met	20% 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	20% 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	20% coinsurance after deductible is met
Diagnostic Services X-Ray		
Office	20% coinsurance after deductible is met	20% 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	20% 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	20% coinsurance after deductible is met
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Radiology Center *Coverage for Out-of-Network Provider is limited to $800 maximum per test*	20% coinsurance after deductible is met	20% 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	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
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$15 copay per visit deductible does not apply	20% coinsurance after deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$50 copay per visit and then 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. The $50,000 limit does not apply to air ambulance services.*	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	20% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Ambulatory Surgical Center *Coverage for Out-of-Network Provider is limited to $350 maximum per visit*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) *Member is responsible for an additional 10% coinsurance 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	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Therapy Services		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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	20% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 100 days per benefit period.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Inpatient Hospice	10% coinsurance after deductible is met	10% coinsurance after deductible is met
Additional Services, Equipment and Devices		
Durable Medical Equipment	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Wigs *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Hearing Aids *Coverage is limited to 1 item per ear every 3 years.*	20% coinsurance after deductible is met	20% 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	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	$5,350 person / $10,200 family	Not applicable

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.*
For more information, refer to "National Drug List" at https://www.anthem.com/ca/pharmacy-information/.

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
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-supply for 2 X the retail co-pay.* **Specialty Pharmacy:** *30 day supply at retail and home delivery (cost shares noted below apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*		
Preventive Drugs *No deductible, copayment or coinsurance applies to prescription drugs on the PreventiveRX Plus drug list when you use an In-Network Pharmacy.*		
Tier 1 - Typically Generic	$5 copay per prescription (retail) and $10 copay per prescription (home delivery)	$5 copay per prescription plus 50% coinsurance up to $250 per prescription plus costs in excess of the max allowed amount (retail only)
Tier 2 - Typically Preferred Brand	$20 copay per prescription (retail) and $40 copay per prescription (home delivery)	$20 copay per prescription plus 50% coinsurance up to $250 per prescription plus costs in excess of the max allowed amount (retail only)
Tier 3 - Typically Non-Preferred Brand	$50 copay per prescription (retail) and $100 copay per prescription (home delivery)	$50 copay per prescription plus 50% coinsurance up to $250 per prescription plus costs in excess of the max allowed amount (retail only)
Tier 4 - Typically Specialty (brand and generic)	$5 copay per prescription (Generic Specialty) 20% coinsurance up to $100 per prescription (Brand	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	Specialty)	

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 Hospital and Ambulatory Surgical Centers; Allergy Testing.
- 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.

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.

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

Anthem

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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 with translations or interpreter services, in a timely manner, please call the telephone number on the back of your ID card. (TTY/TDD: 711). For more help call the CA Dept. of Insurance at 1-800-927-4357 (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 puede leerla, podemos hacer que alguien lo ayude a leerla. También es posible que pueda recibir esta carta escrita en su idioma.
Para obtener ayuda gratuita con traducciones o servicios de interpretación, de manera oportuna, llame al número de teléfono que figura en el dorso de su tarjeta de identificación. (TTY/TDD: 711). Para obtener más ayuda llame al Departamento de Seguros de California al 1-800-927-4357 (TTY/TDD: 711)

Arabic

هام: هل يمكنك قراءة هذا الخطاب؟ إذا كان لا يمكنك ذلك، يمكننا أن نوفر لك شخصًا ما ليساعدك على قراءته. يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية بشأن الترجمات المكتوبة والفورية، وفي الوقت المناسب، يُرجى الاتصال برقم الهاتف المكتوب على ظهر بطاقة ID الخاصة بك.
(TTY/TDD: 711). للحصول على المزيد من المساعدة اتصل على إدارة التأمين في CA على الرقم 1-800-927-4357 (TTY/TDD: 711)

Armenian

նամակը: Եթե ոչ, մեր մասնագետներից մեկը կարող է օգնել ձեզ կարդալ այն: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Թարգմանությունների կամ թարգմանչական ծառայությունների անվճար և ժամանակին օգնության համար խնդրում ենք զանգահարել ձեր ID քարտի հակառակ կողմում նշված հեռախոսահամարով: (TTY/TDD՝ 711): Ավելի շատ օգնության համար զանգահարեք CA-ի ապահովագրության բաժին՝ 1-800-927-4357 հեռախոսահամարով (TTY/TDD՝ 711):

Chinese

重要提示：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。如需及時獲得免費的翻譯或口譯服務協助，請撥打您 ID 卡背面的電話號碼。(TTY/TDD: 711)。欲取得其他協助，請致電 1-800-927-4357 (TTY/TDD: 711) 與 CA 保險部聯絡。

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم ترتیبی دهیم که کسی در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به‌صورت کتبی به زبان خودتان دریافت کنید. برای کمک رایگان و به‌موقع در خدمات ترجمه کتبی و شفاهی، لطفاً با شماره تلفن مندرج در پشت کارت ID خود تماس بگیرید. (TTY/TDD: 711) برای دریافت کمک بیشتر، با اداره بیمه CA به شماره 1-800-927-4357 تماس بگیرید (TTY/TDD: 711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम किसी से इसे पढ़ने में आपकी मदद करवा सकते हैं। आप इस पत्र को अपनी भाषा में भी लिखवा सकते हैं। अनुवाद या द्विभाषिया सेवाओं में मुफ़्त मदद के लिए, कृपया समय पर अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करें। (TTY/TDD: 711) । अधिक सहायता के लिए कैलिफ़ोर्निया बीमा विभाग को CA 1-800-927-4357 (TTY/TDD: 711) पर कॉल करें।

Hmong

TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Yog nyeem tsis tau, peb muaj neeg los pab koj nyeem nws. Koj los yeej tuaj yeem tau txais daim ntawv no ua koj yam lus. Kom tau txais kev pab txhais ntaub ntawv los sis cov kev pab cuam txhais lus pab dawb, kom raws sij hawm, thov hu tus npawb xov tooj nyob sab nraum qab ntawm koj daim npawv ID. (TTY/TDD: 711). Rau kev pab ntxiv hu lub CA Lub Tuam Tsev Hauj Lwm ntsig txog Kev Tuav Pov Hwm ntawm 1-800-927-4357 (TTY/TDD: 711)

Japanese
重要：この手紙を読むことができますか？もし読めない場合は、読むのを手伝ってもらうことができます。 また、この手紙をお使いの言語で入手できる場合もあります。翻訳や通訳サービスの無料サポートが必要な場合は、お持ちの ID カード裏面に記載されている電話番号まで、できるだけ早くお電話ください。（TTY/TDD: 711）さらに詳しいサポートが必要な場合は、CA カリフォルニア州保険局までご連絡ください。電話番号：1-800-927-4357（TTY/TDD: 711）

Khmer
ចំណុចសំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះដែរឬទេ? ប្រសិនបើមិនទេនោះ យើងអាចឱ្យអ្នកណាម្នាក់ជួយអ្នកអានវាបាន។ អ្នកក៏អាចឱ្យគេសរសេរសំបុត្រនេះជាភាសារបស់អ្នកបានផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃជាមួយនឹងសេវាបកប្រែឯកសារ ឬផ្នាល់មាត់ឱ្យខាន់ពេលវេលា សូមទូរស័ព្ទទៅកាន់លេខនៅផ្នែកខ្នងកាត ID សម្គាល់របស់អ្នក។ (TTY/TDD: 711)។ សម្រាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅកាន់ក្រសួងធានាភ័ស្តុងនៃរដ្ឋ CA តាមលេខ 1-800-927-4357 (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있습니까? 그렇지 않다면 서신을 읽을 수 있게 도움을 드릴 수 있습니다. 원하시는 언어로 이 서신을 받으실 수도 있습니다. 번역이나 통역 서비스를 무료로 적시에 이용하시려면 ID 카드 뒷면에 있는 전화번호로 전화해 주십시오. (TTY/TDD: 711). 추가 도움이 필요하시면 CA 보험부에 1-800-927-4357 (TTY/TDD: 711)번으로 전화해 주십시오.

Punjabi
ਮਹੱਤਵਪੂਰਨ ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਅਨੁਵਾਦ ਜਾਂ ਦੁਭਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਵਿੱਚ ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਸਮੇਂ ਸਿਰ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਟੈਲੀਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711). ਹੋਰ ਮਦਦ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 (TTY/TDD: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian
ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш сотрудник поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Чтобы своевременно получить бесплатные услуги письменного или устного перевода, позвоните по номеру телефона, указанному на оборотной стороне вашей идентификационной карты участника (TTY/TDD: 711). Для получения дополнительной помощи позвоните в Департамент страхования штата CA по номеру 1-800-927-4357 (TTY/TDD: 711)

Tagalog
MAHALAGA: Puwede mo bang basahin ang sulat na ito? Kung hindi, puwede tayong humanap ng taong tutulong sa iyo na basahin ito. Maaaring matanggap mo rin ang sulat na ito sa iyong wika. Para sa libreng tulong sa pagsasalin-wika o mga serbisyo ng interpreter, na napapanahon, mangyaring tawagan ang numero ng telepono sa likod ng iyong card ng ID. (TTY/TDD: 711). Para sa higit pang tulong tawagan ang Departamentol ng Insurance ng CA sa 1-800-927-4357 (TTY/TDD: 711)

Thai
ข้อสำคัญ: คุณอ่านจดหมายนี้ได้หรือไม่ หากไม่ได้ เรามีคนช่วยอ่านให้คุณหรือสามารถขอให้ส่งจดหมายนี้เป็นภาษาที่คุณต้องการ ขอความช่วยเหลือด้านการแปลหรือบริการล่ามที่รวดเร็วโดยติดต่อหมายเลขโทรศัพท์ที่ด้านหลังบัตรประจำตัวของคุณ (TTY/TDD: 711).
ขอความช่วยเหลือเพิ่มเติมโดยติดต่อ CA ฝ่ายประกันภัยที่หมายเลข 1-800-927-4357 (TTY/TDD: 711).

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc được lá thư này không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc. Quý vị cũng có thể yêu cầu nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí về dịch vụ biên dịch hoặc thông dịch, vui lòng gọi số điện thoại ở mặt sau thẻ ID của quý vị để được hỗ trợ kịp thời. (TTY/TDD: 711). Để được giúp đỡ thêm, hãy gọi Sở Bảo hiểm CA theo số 1-800-927-4357 (TTY/TDD: 711).

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