Disclosure Form Part One

VALLEY CENTER MUNICIPAL WATER DISTRICT
CID# 104350 HMO
MEMBER SERVICES 800-464-4000
Home Region: Southern California

1/1/26 through 12/31/26

Principal benefits for Kaiser Permanente Traditional HMO Plan

Health Plan believes this coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call Member Services.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	No charge
Most Physician Specialist Visits	No charge
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	No charge
Most physical, occupational, and speech therapy	No charge
Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge
Physician Specialist Visits by interactive video or telephone	No charge
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Services and Care	**You Pay**
Emergency department visits	$50 per visit
Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see “Hospital Inpatient Services” for inpatient Cost Share)	
Ambulance Services	**You Pay**
Ambulance Services	$50 per trip
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service	$5 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service	$5 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	$5 for up to a 30-day supply
Durable Medical Equipment (DME)	**You Pay**
Base DME items as described in the *EOC* (supplemental DME items are not covered)	20% Coinsurance

(continues)

Disclosure Form Part One

(continued)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	No charge
Group outpatient mental health treatment	No charge
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	No charge
Group outpatient substance use disorder treatment	No charge
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Eyeglasses or contact lenses every 24 months	Amount in excess of $100 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Base prosthetic and orthotic devices as described in the *EOC* (supplemental prosthetic and orthotic devices are not covered)	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*.

Disclosure Form Part Two

The *Disclosure Form Part Two* provides an overview of important features of your Health Plan membership, including how to obtain Services, principal exclusions, and important notices. To view or download a copy, go to **kp.org/choosekp** or call Member Services at 1-800-464-4000 (TTY users call 711).

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Southern California

2026 Disclosure Form Amendment for Chiropractic Services

This document amends your Kaiser Foundation Health Plan, Inc. *Disclosure Form* to add coverage for Chiropractic Services.

July 24, 2025

Your Kaiser Permanente Chiropractic Benefit

Benefit Highlights

Professional Services (ASH Participating Provider office visits)	You Pay
Chiropractic office visits (up to a total of 20 visits per 12-month period) ..	$5 per visit

Other	You Pay
X-rays and laboratory tests that are covered Chiropractic Services	No charge
Chiropractic supports and appliances	Amounts in excess of the $50 Allowance

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, refer to the Chiropractic Services amendment to your Health Plan *EOC*.

Introduction

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. ("ASH Plans") to make the network of ASH Participating Providers available to you. When you need chiropractic care, you have direct access to more than 3,000 licensed chiropractors in California.

In addition to the terms defined in the "Definitions" section of your *Disclosure Form*, some capitalized terms have special meaning in this document, as described in the "Definitions" section at the end of this document.

This amendment is only a summary of your chiropractic coverage. The Chiropractic Services Amendment to your *EOC* provides details about the terms and conditions of your chiropractic coverage, including exclusions and limitations.

To obtain the amendment to your *EOC* please contact your group.

ASH Participating Providers

The list of ASH Participating Providers is available on the ASH Plans Website at **ashlink.com/ash/kp** or from the ASH Plans Customer Service Department at **1-800-678-9133** (TTY users call 711) weekdays, hours may vary. The list of ASH Participating Providers is subject to change at any time without notice.

How to Obtain Services

You can obtain services from any ASH Participating Providers without a referral from a Plan Physician.

To obtain services, call an ASH Participating Provider to schedule an initial examination. If additional Services are required after the initial examination, verification that the Services are Medically Necessary may be required. Your ASH Participating Provider will request any required medical necessity determinations. An ASH Plans' clinician in the same or similar specialty as the provider of Services under review will determine whether the Services are or were Medically Necessary Services. For more information about how to obtain covered Services, refer to the Chiropractic Services amendment to your Health Plan *EOC*.

Second Opinions

You may request a second opinion in regard to covered Service by contacting another ASH Participating Provider. Your visit to another ASH Participating Provider for a second opinion generally will count toward any visit limit, if applicable. An ASH Participating Provider may also request a second opinion in regard to covered Services by referring you to another ASH Participating Provider in the same or similar specialty. If you are referred by an ASH Participating Provider to another ASH Participating Provider, or see an ASH Participating Provider for lab work or an X-ray, your visit to the other ASH Participating Provider will not count toward any visit limit. An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial, and of your right to file a grievance as described in your Health Plan *EOC*.

Your Costs

When you receive covered Services, you must pay the Cost Share as described in the Chiropractic Services amendment to your Health Plan *EOC*. The Cost Share does not apply toward the Plan Deductible or Plan Out-of-Pocket Maximum described in the Health Plan *EOC.*

ASH Plans Customer Service

If you have question about the Services you can get from an ASH Participating Provider, you may call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays, hours may vary.

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage under the Chiropractic Services amendment. (Note: Some items and services listed in this “Exclusions” section may be covered Services under your Health Plan *EOC*. Please refer to your Health Plan *EOC* for details.) These exclusions apply to all Services that would otherwise be covered under the Chiropractic Services amendment regardless of whether the services are within the scope of a provider's license or certificate:

- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- Adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under “Chiropractic Supports and Appliances” in the “Covered Services” section of this Amendment
- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational Services. If coverage for a Service is denied because it is experimental or investigational and you want to appeal the denial, refer to your Health Plan *EOC* for information about the appeal process
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other type of diagnostic imaging or radiology other than X-rays covered under the “Covered Services” section of this Amendment
- Ambulance and other transportation
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation

- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California, except for Services covered under "Emergency and Urgent Services Covered Under this Amendment" in the "Covered Services" section
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Maintenance care (services provided to Members whose treatment records indicate that they have reached maximum therapeutic benefit)

Definitions

ASH Participating Provider: A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you. A list of ASH Participating Providers is available on the ASH Plans website at **ashlink.com/ash/kaisercamedicare** for Kaiser Permanente Senior Advantage Members, or **ashlink.com/ash/kp** for all other Members, or from the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**). The list of ASH Participating Providers is subject to change at any time, without notice. If you have questions, please call the ASH Plans Customer Service Department.

ASH Plans: American Specialty Health Plans of California, Inc., a California corporation.

Chiropractic Services: Chiropractic services include spinal and extremity manipulation and adjunctive therapies such as ultrasound, therapeutic exercise, or electrical muscle stimulation, when provided during the same course of treatment and in conjunction with chiropractic manipulative services, and other services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic supports and appliances) for the treatment of your Musculoskeletal and Related Disorder.

Musculoskeletal and Related Disorders: Conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions.

Treatment Plan: The course of treatment for your Musculoskeletal and Related Disorder, which may include laboratory tests, X-rays, chiropractic supports and appliances, and a specific number of visits for chiropractic manipulations (adjustments) and adjunctive therapies that are Medically Necessary Chiropractic Services for you.

VALLEY CENTER MUNICIPAL WATER DISTRICT
CID#104350 KPSA
MEMBER SERVICES 800-464-4000

Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/26—12/31/26)

Plan Out-of-Pocket Maximum	
For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount: For any one Member	$1,000 per calendar year
Plan Deductible	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$15 per visit
Most Physician Specialist Visits	$15 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	$15 per visit
Urgent care consultations, evaluations, and treatment	$15 per visit
Physical, occupational, and speech therapy	$15 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$50 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$15 per visit
Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per admission
Emergency Services	**You Pay**
Emergency department visits	$50 per visit
Ambulance Services	**You Pay**
Ambulance Services	$100 per trip
Prescription Drug Coverage	**You Pay**
This plan covers Medicare Part D prescription drugs in accord with our Part D formulary.	
Initial coverage stage—until you have spent $2,100 in 2026. (If you spend $2,100, you move on to the catastrophic coverage stage)	Generic drugs: $10 for up to a 100-day supply Brand-name drugs: $35 for up to a 100-day supply
Catastrophic coverage stage	No charge
Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use	20 percent Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$500 per admission
Individual outpatient mental health evaluation and treatment	$15 per visit

continued

Mental Health Services	You Pay
Group outpatient mental health treatment	$7 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$500 per admission
Individual outpatient substance use disorder evaluation and treatment	$15 per visit
Group outpatient substance use disorder treatment	$5 per visit

Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge

Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of $150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	20 percent Coinsurance
Fitness benefit – One Pass™ (includes access to in-network gyms and one home fitness kit per calendar year)	No charge

Summary of Benefits **booklet**

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For additional information, please refer to the *Summary of Benefits* booklet enclosed; for a complete explanation, refer to the *EOC*.

Your summary of benefits

ACWA JPIA - C00361

Anthem® Blue Cross Life and Health Insurance Company
Your Plan: 2026 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
Mental Health & Substance Use Disorder Services	No charge
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) and 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
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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	20% coinsurance after deductible is met
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
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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*	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		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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.*
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.*

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
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 (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. 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 (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 prescription (home delivery)	$20 copay per prescription plus 50% coinsurance up to $250 per prescription (retail 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 per prescription plus 50% coinsurance up to $250 per prescription (retail only) plus costs in excess of the max 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 (retail and home delivery)

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.
- 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.
- 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
- 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.

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

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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

Servicios lingüísticos sin costo. Puede solicitar los servicios de un intérprete. También puede solicitar que le leamos y le enviemos algunos documentos en su idioma. Llame al número que figura en su tarjeta de identificación o al 1-888-254-2721. Si necesita más ayuda, llame al Departamento de Seguros de California al 1-800-927-4357 (TTY/TDD: 711).

Arabic

خدمات لغوية مجانية. يمكنك الحصول على مترجم فوري. يمكنك الحصول على مستندات تُقرأ لك وإرسال بعضها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المدرج على بطاقة الهوية الخاصة بك أو 1-800-254-2721. لمزيد من المساعدة اتصل بقسم التأمين في CA على الرقم 1-800-927-4357 (TTY/TDD: 711)

Armenian

Առանց արժեքի լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Դուք կարող եք ստանալ փաստաթղթեր, որոնք կարդում են ձեզ համար, իսկ որոշները՝ ուղարկվում են ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ID քարտում նշված համարով կամ 1-888-254-2721 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք CA Ապահովագրության բաժանմունք՝ 1-800-927-4357 (TTY/TDD՝ 711)

Chinese

免費語言服務。您可獲得口譯員服務。可以把文件唸給您聽，有些文件有您的語言的版本，也可以把這些文件寄給您。欲取得協助，請致電您的 ID 卡所列的電話號碼，或致電 1-888-254-2721 與我們聯絡。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

خدمات زبان بدون هزینه. شما می‌توانید مترجم شفاهی درخواست کنید. می‌توانید بخواهید اسناد برای شما به زبان شما خوانده شود و برخی اسناد به زبان شما برایتان ارسال شود. برای راهنمایی، با ما با شماره مندرج در کارت عضویت خود یا شماره 1-888-254-2721 تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه CA به شماره 1-800-927-4357 (TTY/TDD: 711) تماس بگیرید.

Hindi

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ अपनी भाषा में पढ़वा सकते हैं और कुछ को अपनी भाषा में खुद तक भिजवा सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिए गए नंबर पर या 1-888-254-2721 पर हमें कॉल करें। अधिक सहायता के लिए सीए बीमा विभाग को 1-800-927-4357 पर कॉल करें (TTY/TDD: 711)

Hmong

Tsis Sau Nqi Rau Kev Pab Cuam Txog Lus. Koj tuaj yeem tau txais tus kws txhais lus. Koj tuaj yeem tau txais cov ntaub ntawv kom muab nyeem rau koj mloog thiab kom muab xa rau koj ua yam lus koj hais. Rau kev pab, hu peb tus npawb xov tooj muaj nyob ntawm koj daim npav ID los sis 1-888-254-2721. Rau kev pab ntxiv hu lub CA Tuam Tsev Hauj Lwm ntsig txog Kev Tuav Pov Hwm ntawm 1-800-927-4357 (TTY/TDD: 711)

Japanese

無料の言語サービス。通訳を頼むこともできます。文書を使用言語で読み上げたり、送信したりすることもできます。サポートが必要な場合、ID カードに記載されている電話番号または 1-888-254-2721 までお電話ください。さらに詳しい情報については、カリフォルニア州保険局までお問い合わせください。電話番号：1-800-927-4357（TTY/TDD: 711）

Khmner
មិនគិតថ្លៃសេវាកាសាទេ។ អ្នកអាចទទួលបានអ្នកបកប្រែ។ អ្នកអាចទទួលបានឯកសារអានឱ្យអ្នកស្តាប់ និងឯកសារខ្លះផ្ញើឱ្យអ្នកជាភាសារបស់អ្នក។ សម្រាប់ជំនួយ សូមទូរសព្ទមកយើងតាមលេខដែលមាននៅក្នុងកាត ID របស់អ្នក ឬ 1-888-254-2721។ សម្រាប់ជំនួយបន្ថែម សូមទូរសព្ទទៅផ្នែកជានាយ៉ាប៊ររង CA តាមរយៈលេខ 1-800-927-4357 (TTY/TDD: 711)

Korean
무상 언어 서비스. 통역사를 연결시켜 드립니다. 문서를 귀하에게 읽어드릴 수 있고 어떤 서류는 귀하의 언어로 작성하여 댁으로 보내드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 나와 있는 번호 또는 1-888-254-2721 번으로 전화해 주시기 바랍니다. 더 많은 도움이 필요하시면 CA 보험부에 1-800-927-4357 (TTY/TDD: 711)로 전화해 주십시오.

Punjabi
ਬਿਨਾ ਕੋਈ ਲਾਗਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਲੈ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੜ੍ਹ ਕੇ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਗਏ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ 1-888-254-2721. ਹੋਰ ਮਦਦ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ 1-800-927-4357 (TTY/TDD: 711)

Russian
Доступны бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Вам могут зачитать документы вслух, а некоторые из них могут быть отправлены вам на вашем языке. Если вам нужна помощь, позвоните нам по номеру, указанному на вашей идентификационной карте участника плана, или по номеру 1-888-254-2721. Для получения дополнительной помощи позвоните в Департамент страхования штата California по номеру 1-800-927-4357 (TTY/TDD: 711)

Tagalog
Walang Gastos na mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter. Maaari mong ipabasa ang mga dokumento sa iyo at ipadala sa iyo ang ilan sa nang nasa wika mo. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o 1-888-254-2721. Para sa higit pang tulong tumawag sa CA Dept. of Insurance sa 1-800-927-4357 (TTY/TDD: 711)

Thai
บริการด้านภาษาแบบไม่เสียค่าใช้จ่าย คุณสามารถรับล่ามเพื่อช่วยเหลือได้ คุณสามารถรับเอกสารแบบมีผู้อ่านให้ฟังและส่งให้คุณในภาษาของคุณได้ หากต้องการความช่วยเหลือ โปรดโทรติดต่อเราตามหมายเลขที่ระบุบนบัตรประจำตัวของคุณหรือ 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดต่อกรมการประกันภัยแห่งแคลิฟอร์เนียได้ที่ 1-800-927-4357 (TTY/TDD: 711)

Vietnamese
Dịch vụ Ngôn ngữ Miễn Phí. Quý vị có thể được bố trí thông dịch viên. Quý vị có thể yêu cầu họ đọc tài liệu hoặc gửi cho quý vị một số tài liệu bằng ngôn ngữ của quý vị. Để được trợ giúp, hãy gọi cho chúng tôi theo số điện thoại được ghi trên thẻ ID của quý vị hoặc 1-888-254-2721. Để được trợ giúp thêm, hãy gọi cho Sở Bảo hiểm CA theo số 1-800-927-4357 (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

Your summary of benefits

ACWA JPIA - C00361

Anthem® Blue Cross

Your Plan: 2026 HMO Plan (2940)

Your Network: California Care HMO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	$10 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Overall Deductible	$0 person
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.*	$500 single / $1,500 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 or Urgent 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 single 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 single out-of-pocket limit. All medical copayments and coinsurance apply to the medical out-of-pocket limit.	
Doctor Visits (virtual and office) *Your plan requires the selection of a Primary Care Physician (PCP). A referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services.*	
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$10 copay per visit
Specialist Provider *virtual and office*	$10 copay per visit
Other Practitioner Visits	
Maternity services	
Prenatal and Postpartum care	$10 copay per visit
Delivery	No charge
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$10 copay per visit
Manipulation Therapy *via medical group (Chiropractic Services)*	$10 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 60 visits combined per benefit period.	
Manipulation Therapy via ASH plan provider *Coverage is limited to 30 visits per year. Benefit limit is for office and outpatient combined.*	$10 copay per visit
Acupuncture	$10 copay per visit
Other Services in an Office	
Allergy Testing	$10 copay per visit
Prescription Drugs *Dispensed in the office* *Maximum of $100 member cost share per drug.*	20% coinsurance
Surgery	$10 copay per surgery
Preventive care / screenings / immunizations	No charge
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge
Diagnostic Services Lab	
Office	No charge
Freestanding Lab	No charge
Outpatient Hospital	No charge
Diagnostic Services X-Ray	
Office	No charge
Freestanding Radiology Center	No charge
Outpatient Hospital	No charge
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*	
Office	No charge
Freestanding Radiology Center	No charge
Outpatient Hospital	No charge
Emergency and Urgent Care	
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	**In-Network and Out-of-Network Providers:** $10 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Emergency Room Facility Services *Your copay will be waived if admitted.*	**In-Network and Out-of-Network Providers:** $50 copay per visit
Emergency Room Doctor and Other Services	**In-Network and Out-of-Network Providers:** No charge
Ambulance	**In-Network and Out-of-Network Providers:** $50 copay per trip
Outpatient Mental Health and Substance Use Disorder Services at a Facility	
Facility Fees	No charge
Doctor Services	No charge
Outpatient Surgery	
Facility Fees	
Hospital	No charge
Ambulatory Surgical Center	No charge
Physician and other services *including surgeon fees*	
Hospital	No charge
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)	
Facility Fees	No charge
Physician and other services *including surgeon fees*	No charge
Home Health Care	No charge
Therapy Services	
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and speech therapies and manipulative treatment is limited to 60 visits combined per benefit period.*	
Office	$10 copay per visit
Outpatient Hospital	No charge
Pulmonary rehabilitation	
Office	$10 copay per visit
Outpatient Hospital	No charge
Cardiac rehabilitation	
Office	$10 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Outpatient Hospital	No charge
Dialysis/Hemodialysis Office Outpatient Hospital	 $10 copay per visit No charge
Chemo/Radiation Therapy Office Outpatient Hospital	 $10 copay per visit No charge
Skilled Nursing Care (facility) *Coverage is limited to 100 days per benefit period.*	No charge
Inpatient Hospice	No charge
Additional Services, Equipment and Devices **Durable Medical Equipment**	 No charge
Prosthetic Devices	No charge
Wigs *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	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	$6,100 person / $11,700 family	Not applicable
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***CA National DMHC*** *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) of 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.* **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.*		
Tier 1 - Typically Generic	$5 copay per prescription (retail) and	$5 copay per prescription plus 50%

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	$10 copay per prescription (home delivery)	coinsurance up to $250 per prescription (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 (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 (retail only).
Tier 4 - Typically Specialty (brand and generic)		
Self-Administered Injectable Drugs *(except insulin) Covers up to a 30 day supply (retail pharmacy) and up to 90 day supply (home delivery)*	20% coinsurance up to $100 per prescription (retail) and 20% coinsurance up to $200 per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail only).
Specialty Pharmacy Program *- Certain specialty pharmacy drugs may be obtained through the specialty pharmacy program. Limited to a 30-day supply. Please contact the customer service number on the back of your ID card to see if your drug is on the specialty pharmacy program or obtain a list at anthem.com/ca.*	Applicable copay applies	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	Not covered
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	No charge	Not covered

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 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 health and substance use disorders. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

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

Your summary of benefits

Anthem

Anthem® Blue Cross

Your Plan: Chiropractic-Manipulative Treatment Rider

Your Network: ASH

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Benefits described in this section are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California, Inc. (ASH Plans). The services described in this section are covered only if provided by a chiropractor that is an In-Network Provider. These benefits are in addition to the benefits described in the "Therapy Services" provision within the Evidence of Coverage (EOC). However, when you are treated by a chiropractor that is an In-Network Provider, services will not be covered other than those benefits specifically described in this section. You may search for chiropractors that are In-Network Providers using the "Find Care" function on our website at www.anthem.com/ca and select the HMO Chiropractic/Acupuncture Network (American Specialty Health Plans).		
Your First Visit You must make an appointment with a chiropractor that is an In-Network Provider for an examination of your condition. You do not need a referral from your Medical Group or Primary Care Physician to see a chiropractor that is an In-Network Provider. **Services Must be Approved** All services must be approved as Medically Necessary except for: • An initial new patient exam by a chiropractor that are In-Network Provider and the provision or commencement, during the initial new patient exam, of Medical Necessary services that are chiropractic services, to the extent services are consistent with professionally recognized, valid, evidence-based standards of practice; and • Emergency Services. If additional services are required after the initial new patient exam and they are approved as Medically Necessary, you are covered up to the maximum number of visits shown below. All visits will be applied towards the maximum number of visits in a Benefit Period. **Services Not Approved** A chiropractor that is an In-Network Provider may provide non-Covered Services. However, you must agree in writing, before receiving non-Covered Services, to pay for them yourself. If a chiropractor that is an In-Network Provider provides non-Covered Services without obtaining your written acknowledgement prior to providing the non-Covered Services, you will not be financially responsible to pay the provider for such non-Covered Services.		
Visits in an Office & Outpatient **Chiropractic Care** *Coverage is limited to 30 visits per year. Benefit limit is for office and outpatient combined.*	$10 copay per visit	Not covered
Diagnostic Services **Lab** **Chiropractic labs** *Covered when prescribed by a chiropractor that is an In-Network Provider and approved as Medically Necessary.*	Covered at the same cost share percentage as Diagnostic Labs.	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Chiropractic X-Ray *Covered when prescribed by a chiropractor that is an In-Network Provider and approved as Medically Necessary.*	Covered at the same cost share percentage as Diagnostic X-ray.	Not Covered
Durable Medical Equipment		
Chiropractic appliances *Covered when prescribed by a chiropractor that is an In-Network Provider and approved as Medically Necessary.*	$50 maximum of Chiropractic Appliances per year.	Not Covered

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 health and substance use disorders. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

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 أيضًا 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

مهم: آیا می توانید این نامه را بخوانید؟ اگر نخوانیدنمی توانیم از شخصی بخواهیم که برای شما نامه را بخواند. کتبی صورت به را نامه این بتوانید است ممکن همچنین به زبان خود دریافت کنید. برای دریافت کمک فوراً با ما تماس بگیرید. شماره 1-888-254-2721. (TTY/TDD: 711)

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។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ 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 ਤੁਸੀ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀ, ਤਾਂ ਅਸੀ 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 เราสามารถขอให้ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอจดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน 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

Your summary of benefits

ACWA JPIA C00361

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: 2026 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. Deductible does not apply
Mental Health & Substance Use Disorder Services	No charge. Deductible does not apply
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	$1,700 person / $3,400 family	$1,700 person / $3,400 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 Provider *virtual and office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum 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
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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	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	Cost share is based on the setting services are received.
Diagnostic Services 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
Diagnostic Services 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
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
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 $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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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
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
Therapy Services		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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
Additional Services, Equipment and Devices		
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 deductible is met
Wigs *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hearing Aids *Coverage is limited to 1 item per ear every 3 years.*	20% coinsurance after 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.*

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
*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 (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. 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.* *Certain drugs on the Preventive Rx Plus list may be purchased at the applicable tier co-pay 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) after deductible.	$5 copay per prescription plus 50% coinsurance up to $250 per prescription (retail only) plus costs in excess of the max allowed amount after deductible.
Tier 2 - Typically Preferred Brand	$20 copay per prescription (retail) and $40 copay per prescription (home delivery) after deductible.	$20 copay per prescription plus 50% coinsurance up to $250 per prescription (retail only) plus costs in excess of the max allowed amount after deductible.
Tier 3 - Typically Non-Preferred Brand	$50 copay per prescription (retail) and $100 copay per prescription (home delivery) after deductible.	$50 copay per prescription plus 50% coinsurance up to $250 per prescription (retail only) plus costs in excess of the max allowed amount after deductible.
Tier 4 - Typically Specialty (brand and generic)	$5 copay per prescription (Generic Specialty) 20% coinsurance up to $100 per prescription (Brand Specialty) after deductible.	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.
- 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
- 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.

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: No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. 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

Servicios lingüísticos sin costo. Puede solicitar los servicios de un intérprete. También puede solicitar que le leamos y le enviemos algunos documentos en su idioma. Llame al número que figura en su tarjeta de identificación o al 1-888-254-2721. Si necesita más ayuda, llame al Departamento de Seguros de California al 1-800-927-4357 (TTY/TDD: 711).

Arabic

خدمات لغوية مجانية. يمكنك الحصول على مترجم فوري. يمكنك الحصول على مستندات تُقرأ لك وإرسال بعضها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المدرج على بطاقة الهوية الخاصة بك أو 1-800-254-2721. لمزيد من المساعدة اتصل بقسم التأمين في CA على الرقم 1-800-927-4357 (TTY/TDD: 711)

Armenian

Առանց արժեքի լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Դուք կարող եք ստանալ փաստաթղթեր, որոնք կարդում են ձեզ համար, իսկ որոշները՝ ուղարկվում են ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ID քարտում նշված համարով կամ 1-888-254-2721 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք CA Ապահովագրության բաժանմունք՝ 1-800-927-4357 (TTY/TDD՝ 711)

Chinese

免費語言服務。您可獲得口譯員服務。可以把文件唸給您聽，有些文件有您的語言的版本，也可以把這些文件寄給您。欲取得協助，請致電您的 ID 卡所列的電話號碼，或致電 1-888-254-2721 與我們聯絡。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

خدمات زبان بدون هزینه. شما می‌توانید مترجم شفاهی درخواست کنید. می‌توانید بخواهید اسناد برای شما به زبان شما خوانده شود و برخی اسناد به زبان شما برایتان ارسال شود. برای راهنمایی، با ما با شماره مندرج در کارت عضویت خود یا شماره 1-888-254-2721 تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه CA به شماره 1-800-927-4357 (TTY/TDD: 711) تماس بگیرید.

Hindi

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ अपनी भाषा में पढ़वा सकते हैं और कुछ को अपनी भाषा में खुद तक भिजवा सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिए गए नंबर पर या 1-888-254-2721 पर हमें कॉल करें। अधिक सहायता के लिए सीए बीमा विभाग को 1-800-927-4357 पर कॉल करें (TTY/TDD: 711)

Hmong

Tsis Sau Nqi Rau Kev Pab Cuam Txog Lus. Koj tuaj yeem tau txais tus kws txhais lus. Koj tuaj yeem tau txais cov ntaub ntawv kom muab nyeem rau koj mloog thiab kom muab xa rau koj ua yam lus koj hais. Rau kev pab, hu peb tus npawb xov tooj muaj nyob ntawm koj daim npav ID los sis 1-888-254-2721. Rau kev pab ntxiv hu lub CA Tuam Tsev Hauj Lwm ntsig txog Kev Tuav Pov Hwm ntawm 1-800-927-4357 (TTY/TDD: 711)

Japanese

無料の言語サービス。通訳を頼むこともできます。文書を使用言語で読み上げたり、送信したりすることもできます。サポートが必要な場合、ID カードに記載されている電話番号または 1-888-254-2721 までお電話ください。さらに詳しい情報については、カリフォルニア州保険局までお問い合わせください。電話番号：1-800-927-4357（TTY/TDD: 711）

Khmner
មិនគិតថ្លៃសេវាកាសាទេ។ អ្នកអាចទទួលបានអ្នកបកប្រែ។ អ្នកអាចទទួលបានឯកសារអានឱ្យអ្នកស្តាប់ និងឯកសារខ្លះផ្ញើឱ្យអ្នកជាភាសារបស់អ្នក។ សម្រាប់ជំនួយ សូមទូរសព្ទមកយើងតាមលេខដែលមាននៅក្នុងកាត ID របស់អ្នក ឬ 1-888-254-2721។ សម្រាប់ជំនួយបន្ថែម សូមទូរសព្ទទៅផ្នែកជានាយ៉ាប៊ររង CA តាមរយៈលេខ 1-800-927-4357 (TTY/TDD: 711)

Korean
무상 언어 서비스. 통역사를 연결시켜 드립니다. 문서를 귀하에게 읽어드릴 수 있고 어떤 서류는 귀하의 언어로 작성하여 댁으로 보내드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 나와 있는 번호 또는 1-888-254-2721 번으로 전화해 주시기 바랍니다. 더 많은 도움이 필요하시면 CA 보험부에 1-800-927-4357 (TTY/TDD: 711)로 전화해 주십시오.

Punjabi
ਬਿਨਾ ਕੋਈ ਲਾਗਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਲੈ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੜ੍ਹ ਕੇ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਗਏ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ 1-888-254-2721. ਹੋਰ ਮਦਦ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ 1-800-927-4357 (TTY/TDD: 711)

Russian
Доступны бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Вам могут зачитать документы вслух, а некоторые из них могут быть отправлены вам на вашем языке. Если вам нужна помощь, позвоните нам по номеру, указанному на вашей идентификационной карте участника плана, или по номеру 1-888-254-2721. Для получения дополнительной помощи позвоните в Департамент страхования штата California по номеру 1-800-927-4357 (TTY/TDD: 711)

Tagalog
Walang Gastos na mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter. Maaari mong ipabasa ang mga dokumento sa iyo at ipadala sa iyo ang ilan sa nang nasa wika mo. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o 1-888-254-2721. Para sa higit pang tulong tumawag sa CA Dept. of Insurance sa 1-800-927-4357 (TTY/TDD: 711)

Thai
บริการด้านภาษาแบบไม่เสียค่าใช้จ่าย คุณสามารถรับล่ามเพื่อช่วยเหลือได้ คุณสามารถรับเอกสารแบบมีผู้อ่านให้ฟังและส่งให้คุณในภาษาของคุณได้ หากต้องการความช่วยเหลือ โปรดโทรติดต่อเราตามหมายเลขที่ระบุบนบัตรประจำตัวของคุณหรือ 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดต่อกรมการประกันภัยแห่งแคลิฟอร์เนียได้ที่ 1-800-927-4357 (TTY/TDD: 711)

Vietnamese
Dịch vụ Ngôn ngữ Miễn Phí. Quý vị có thể được bố trí thông dịch viên. Quý vị có thể yêu cầu họ đọc tài liệu hoặc gửi cho quý vị một số tài liệu bằng ngôn ngữ của quý vị. Để được trợ giúp, hãy gọi cho chúng tôi theo số điện thoại được ghi trên thẻ ID của quý vị hoặc 1-888-254-2721. Để được trợ giúp thêm, hãy gọi cho Sở Bảo hiểm CA theo số 1-800-927-4357 (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

Summary of Benefits

January 1, 2026 - December 31, 2026

This is a summary of what we cover and what you pay. Review the Evidence of Coverage (EOC) for a complete list of covered services, limitations and exclusions. You can call Customer Service if you want a copy of the EOC or need help. When you enroll in the plan, you will get more information on how to view your plan details online.

UnitedHealthcare® Group Medicare Advantage (PPO)

Medical premium and limits	
	In-network and out-of-network
Monthly plan premium	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
Maximum out-of-pocket amount (does not include prescription drugs)	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $200 for this plan year. If you reach the limit on out-of-pocket costs, you keep getting covered for hospital and medical services and we will pay the full cost for the rest of the plan year. Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.

Medical benefits		
		In-network and out-of-network
Inpatient hospital care[1]		$0 copay per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient hospital[1] Cost sharing for additional plan	Ambulatory surgical center (ASC)	$0 copay
	Outpatient surgery	$0 copay

Medical benefits		
		In-network and out-of-network
covered services will apply.	Outpatient hospital services, including observation	$0 copay
Doctor visits	Primary care provider (PCP)	$0 copay
	Virtual visit	$0 copay
	Specialist[1]	$0 copay
Preventive services	Routine physical	$0 copay; 1 per plan year*
	Medicare-covered	$0 copay

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Annual wellness visit
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screening
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings and monitoring
- Diabetes – Self-Management training
- Dialysis training
- Glaucoma screening
- Hepatitis C screening
- HIV screening
- Kidney disease education
- Lung cancer with low dose computed tomography (LDCT) screening
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screenings and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19
- “Welcome to Medicare” preventive visit (one-time)

Medical benefits		
		In-network and out-of-network
	Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100%.	
Emergency care		$50 copay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the emergency care copay. See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently needed services		$0 copay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the urgently needed services copay. See the "Inpatient Hospital Care" section of this booklet for other costs.
Diagnostic tests, lab and radiology services, and X-rays	Diagnostic radiology services (e.g. MRI, CT scan)[1]	$0 copay
	Lab services[1]	$0 copay
	Diagnostic tests and procedures[1]	$0 copay
	Therapeutic radiology[1]	$0 copay
	Outpatient X-rays[1]	$0 copay
Hearing services	Exam to diagnose and treat hearing and balance issues[1]	$0 copay
	Routine hearing exam	$0 copay, 1 exam per plan year*

Medical benefits		
		In-network and out-of-network
	Hearing Aids UnitedHealthcare Hearing	Through UnitedHealthcare Hearing, the plan pays a $2,500 allowance for hearing aids (combined for both ears) every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing.
Vision services	Exam to diagnose and treat diseases and conditions of the eye[1]	$0 copay
	Eyewear after cataract surgery	$0 copay
	Routine eye exam	$0 copay, 1 exam every 12 months*
Mental health	Inpatient visit[1]	$0 copay per stay, up to 190 days
		Our plan covers 190 days for an inpatient hospital stay.
	Outpatient group therapy visit[1]	$0 copay
	Outpatient individual therapy visit[1]	$0 copay
	Outpatient therapy or office visit with a psychiatrist[1]	$0 copay
	Virtual behavioral visits	$0 copay
Skilled nursing facility (SNF)[1]		$0 copay per day: days 1-20 $0 copay per day: days 21-100
		Our plan covers up to 100 days in a SNF per benefit period.
Outpatient Rehabilitation (physical, occupational, or speech/language therapy)[1]		$0 copay
Ambulance[2]		$0 copay

Medical benefits		
		In-network and out-of-network
Routine transportation		Not covered
Medicare Part B Drugs Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.	Chemotherapy drugs[1]	$0 copay
	Other Part B drugs[1]	$0 copay

Prescription drugs		
Deductible	The plan does not have a prescription drug deductible. Your coverage starts in the Initial Coverage stage.	
Initial coverage	In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of $2,100 you move to the Catastrophic Coverage stage.	
Tier drug coverage (After you pay your deductible, if applicable)	**Retail Cost-Sharing**	**Mail Order or Retail Cost-Sharing**
	30-day supply	**90-day supply**
Tier 1: Preferred Generic	$5 copay	$10 copay
Tier 2: Preferred Brand ~	$20 copay	$40 copay
Tier 3: Non-Preferred Drug ~	$50 copay	$100 copay
Tier 4: Specialty Tier ~	$50 copay (limited to a 30-day supply)	$50 copay (limited to a 30-day supply)

Prescription drugs	
Catastrophic coverage	Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year. If your plan includes additional prescription drug coverage, you will continue to pay the cost-sharing amounts from the Initial Coverage stage for those drugs. Please see your Additional Drug Coverage list for more information.

˜ You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan. Most adult Part D vaccines are covered at no cost to you.

If the actual cost for a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

Your plan sponsor offers drug coverage in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D benefit and your additional drug coverage. For more information, see your Additional Drug Coverage list. You can also view the Certificate of Coverage at **retiree.uhc.com** or call Customer Service to have a hard copy sent to you.

If you reside in a long-term care facility, you will pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

You may qualify for Extra Help from Medicare

Extra Help is a program for people with limited incomes who need help paying Part D premiums, deductibles and copays. There's no penalty for applying, and you can re-apply every year. To see if you qualify for Extra Help, call:

- The Social Security Administration at 1-800-772-1213, TTY 1-800-325-0778
- Your state Medicaid office

The UnitedHealthcare Savings Promise

UnitedHealthcare is committed to keeping your prescription drug costs down. As a UnitedHealthcare member, you have our Savings Promise that you'll get the lowest price available. That low price may be your plan copay, the pharmacy's retail price or our contracted price with the pharmacy.

Additional benefits		
		In-network and out-of-network
Acupuncture services	Medicare-covered acupuncture (for chronic low back pain)	$0 copay
	Routine acupuncture services	$0 copay, up to 20 visits per plan year*
Chiropractic services	Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)[1]	$0 copay
	Routine chiropractic services	$0 copay, up to 30 visits per plan year*
Diabetes management	Diabetes monitoring supplies[1]	$0 copay We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan. Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide. Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus.
	Medicare covered Continuous Glucose Monitors (CGMs) and supplies[1]	$0 copay
	Diabetes self-management training	$0 copay
	Therapeutic shoes or inserts[1]	$0 copay

Additional benefits		
		In-network and out-of-network
Durable medical equipment (DME) and related supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)[1]	$0 copay
	Prosthetics (e.g., braces, artificial limbs)[1]	$0 copay
 **Fitness program** Renew Active by UnitedHealthcare		$0 copay for Renew Active by UnitedHealthcare, a Medicare fitness program. It includes a gym membership at a fitness location you select from our national network, plus online classes and fun activities outside of the gym, at no additional cost. Sign in to your member site, look for My Coverage and select Access gym code or call the number on your UnitedHealthcare UCard® to obtain your code.
Foot care (podiatry services)	Foot exams and treatment[1]	$0 copay
	Routine foot care	$0 copay, 6 visits per plan year*
Over-the-counter (OTC) credit		$40 credit each quarter to buy covered OTC products from network retail locations or through the website. Credits expire the last day of each quarter.
 **UnitedHealthcare Healthy at Home** Post-discharge program		$0 copay for the following benefits for up to 30 days following each inpatient hospital and SNF stay: □28 home-delivered meals, referral required □12 one-way trips to medically related appointments and the pharmacy, up to 50 miles per trip, referral required □6 hours of non-medical personal care services like companionship, meal prep, medication reminders and more with a professional caregiver, no referral required Services must be provided by approved vendors. Call Customer Service for more information, to request a referral after each discharge and to use your benefits.
 **Home health care**[1]		$0 copay

Additional benefits		
		In-network and out-of-network
Hospice		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.
Opioid treatment program services[1]		$0 copay
Outpatient substance use disorder services	Outpatient group therapy visit[1]	$0 copay
	Outpatient individual therapy visit[1]	$0 copay
Diabetes Prevention and Weight Management Program		$0 copay for Real Appeal®, an online weight management and healthy lifestyle program proven to help you achieve lifelong results. Call or go online to get started today. 1-844-924-7325, TTY 711 or uhc.realappeal.com *Real Appeal is available at no additional cost to members with a BMI of 19 and higher. If you are pregnant, please speak with your primary care provider (PCP) before joining the program.
Renal dialysis[1]		$0 copay

[1] Some of the network benefits listed may require your provider to obtain prior authorization. You never need approval in advance for plan covered services from out-of-network providers. Please refer to the Evidence of Coverage for a complete list of services that may require prior authorization.
[2] Authorization is required for non-emergency Medicare-covered ambulance air transportation. Authorization is not required for non-emergency Medicare-covered ambulance ground transportation. Emergency ambulance (ground or air) does not require authorization.

*Benefits are combined in and out-of-network

About this plan

UnitedHealthcare® Group Medicare Advantage (PPO) is a Medicare Advantage PPO plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area as listed below, be a United States citizen or lawfully present in the United States, and meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

Our service area includes the 50 United States, the District of Columbia and all US territories.

About providers and network pharmacies

UnitedHealthcare® Group Medicare Advantage (PPO) has a network of doctors, hospitals, pharmacies and other providers. You can see any provider (network or out-of-network) at the same cost share, as long as they accept the plan and have not opted out of or been excluded or precluded from the Medicare program. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to **retiree.uhc.com** to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.