

Prescription Drug Summary of Benefits: 01/01/2025 – 12/31/2025
Formulary E3, 10/20/20 (with Senior Rx Plus)

Western Teamsters Welfare Trust

About this plan

Anthem BC Health Insurance Company gives you the tools and resources to make the best decisions for your health, like this summary of benefits. It's a snapshot of your plan's covered benefits and services and what they cost. This Summary of Benefits doesn't list every service we cover or every limitation or exclusion. For more details about your benefits and services, please review your *Evidence of Coverage* (EOC). You can access your EOC online by logging into the member portal at www.anthem.com/CA, or you can call Member Services with any questions you may have.

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, DC, and all United States territories.

How much is the monthly premium?:

Contact your group plan benefit administrator to determine your actual premium amount, if applicable.

Questions?

Call our **Member Services Team** for answers or plan details and provide them with this group specific code CA049GRS.

Prospective Members, please contact your benefit administrator. When you enroll in the plan you will receive information that tells you where to go online to view your *Evidence of Coverage*.

How much is the monthly premium?

Contact your group plan benefit administrator to determine your actual premium amount, if applicable.

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Stage 1 Annual Deductible Stage

In this stage, you pay a set amount. Once you reach this amount, your plan begins to pay its share of the cost.

Deductible: \$0

Stage 2 Initial Coverage Stage

Below is your payment responsibility until the amount paid by you for covered prescriptions reaches your Drug Plan Maximum Out of Pocket of \$2,000.

Retail Pharmacy	Preferred Network Pharmacy		Standard Network Pharmacy		Mail-Order Pharmacy
	per 30-day supply	per 90-day supply	per 30-day supply	per 90-day supply	per 90-day supply
Tier 1: Generics	\$5	\$10	\$10	\$20	\$20
Tier 1: Select Generics	\$0	\$0	\$0	\$0	\$0
Tier 2: Preferred Drugs	\$10	\$20	\$20	\$40	\$40
Tier 3: Non-Preferred Drugs, including Specialty Drugs	\$10	\$20	\$20	\$40	\$40

Stage 3 Catastrophic Coverage Stage

Your responsibility for payment of covered drugs changes once you reach your Drug Plan Maximum Out of Pocket of \$2,000.

Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
All Tiers: All Part D Covered Prescription Drugs	\$0

- **Important Message About What You Pay for Vaccines:** All Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are covered at no cost to you.
- **Important Message About What You Pay for Insulin:** You won't pay more than \$35 for a one month supply of each insulin product covered by your plan, no matter what cost-sharing tier it is on.

Extra Covered Drugs Benefits Chart

Retail Pharmacy	Preferred Network Pharmacy	Standard Network Pharmacy	Mail-Order Pharmacy
	per 30-day supply	per 30-day supply	per 90-day supply
Cough and Cold DESI Vitamins and Minerals	See Drug List for complete list of drugs covered		
Tier 1: Generics	\$5	\$10	\$20
Tier 2: Preferred Drugs	\$10	\$20	\$40
Tier 3: Non-Preferred Drugs	\$10	\$20	\$40

Retail Pharmacy	Preferred Network Pharmacy	Standard Network Pharmacy	Mail-Order Pharmacy
	per 30-day supply	per 30-day supply	per 90-day supply
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.		
Tier 1: Generics	\$5	\$10	\$20
Tier 2: Preferred Drugs	\$10	\$20	\$40
Tier 3: Non-Preferred Drugs	\$10	\$20	\$40
Other Non-Part D Coverage	Copay or coinsurance		
Contraceptive Devices	\$10 per Covered Device	\$20 per Covered Device	\$20 per Covered Device

This document reflects cost shares only.

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, coinsurance, and restrictions may apply.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Medicare & You 2025 resource: For more information, we encourage you to read Medicare & You 2025. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at www.medicare.gov. Or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.