

Your summary of benefits



Anthem® Blue Cross

Your Plan: REEP - Combined: Custom Value Deductible HMO \$500 40/0 0% (HMO 40 w/o Chiro)

Your Network: Select HMO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$500 person / \$1,000 family	Not covered
Out-of-Pocket Limit	\$1,500 single / \$4,500 family	Not covered
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per single out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per single out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p>		
Preventive Care / Screening / Immunization	No charge	Not covered
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Not covered
<u>Virtual Care (Telemedicine / Telehealth Visits)</u> Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	\$40 copay per visit deductible does not apply	Not covered
Mental Health and Substance Use Disorder care	No charge	Not covered
Specialist	\$40 copay per visit deductible does not apply	Not covered
Virtual Visits from Online Provider LiveHealth Online <i>via www.livehealthonline.com; our mobile app, website or Anthem-enabled device</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder	No charge	Not covered

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Questions: (833) 913-2236 or visit us at www.anthem.com/ca

CA/LG/REEP - Combined: Custom Value Deductible HMO \$500 40/0 0% (HMO 40 w/o Chiro)/0UW2/07-01-2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care	\$40 copay per visit deductible does not apply	Not covered
<u>Visits in an Office</u>		
Primary Care (PCP)	\$40 copay per visit deductible does not apply	Not covered
Specialist Care	\$40 copay per visit deductible does not apply	Not covered
<u>Other Practitioner Visits</u>		
Routine Maternity Care (Prenatal and Postnatal)	\$40 copay per visit deductible does not apply	Not covered
Retail Health Clinic	\$40 copay per visit deductible does not apply	Not covered
Acupuncture	\$40 copay per visit deductible does not apply	Not covered
<u>Other Services in an Office</u>		
Allergy Testing	No charge	Not covered
Chemo/Radiation Therapy	No charge	Not covered
Dialysis/Hemodialysis	No charge	Not covered
Prescription Drugs <i>Dispensed in the office</i>	No charge	Not covered
Surgery	\$40 copay per surgery deductible does not apply	Not covered
<u>Diagnostic Services</u>		
Lab		
Office	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Lab	No charge	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
X-Ray		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i>		
Office	\$40 copay per service deductible does not apply	Not covered
Freestanding Radiology Center	\$40 copay per service deductible does not apply	Not covered
Outpatient Hospital	\$40 copay per service after deductible is met	Not covered
<u>Emergency and Urgent Care</u>		
Urgent Care <i>Copay waived if admitted.</i>	\$40 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Facility Services <i>Copay waived if admitted.</i>	\$100 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	No charge	Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder</u>		
Doctor Office Visit	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Visit		
Facility Fees	0% coinsurance after deductible is met	Not covered
Doctor Services	No charge	Not covered
<u>Outpatient Surgery</u>		
Facility Fees		
Hospital	\$250 copay per visit after deductible is met	Not covered
Freestanding Surgical Center	\$250 copay per visit after deductible is met	Not covered
Doctor and Other Services		
Hospital	No charge	Not covered
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u>		
Facility Fees	\$250 copay per admission after deductible is met	Not covered
Doctor and other services	No charge	Not covered
<u>Recovery & Rehabilitation</u>		
Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	No charge	Not covered
Rehabilitation services <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech combined is limited to 60 days per benefit period.</i>		
Office	No charge	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i> Office Outpatient Hospital	\$40 copay per visit deductible does not apply 0% coinsurance after deductible is met	Not covered Not covered
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	0% coinsurance after deductible is met	Not covered
Inpatient Hospice	0% coinsurance after deductible is met	Not covered
Durable Medical Equipment	0% coinsurance after deductible is met	Not covered
Prosthetic Devices	0% coinsurance after deductible is met	Not covered
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not covered	Not covered
Pharmacy Out-of-Pocket Limit	Not covered	Not covered
Prescription Drug Coverage		
Home Delivery Pharmacy		
Tier 1 - Typically Generic	Not covered (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	Not covered (retail and home delivery)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 3 - Typically Non-Preferred Brand	Not covered (retail and home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	Not covered (retail and home delivery)	Not covered (retail and home delivery)

Notes:

- Your plan requires the selection of a Primary Care Physician (PCP). Choosing a PCP is an important decision. Call us at the number on your ID card and we'll help you pick a doctor. Additionally, a referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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 and nervous disorders and substance abuse. 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 alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

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

Arabic

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

Armenian

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

Chinese

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

Farsi

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

Hindi

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

Hmong

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

Japanese

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

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឱ្យមនុស្សម្នាក់អានជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសេរីដោយសារតែភាសាប្រសិនបើអ្នកមិនដឹង។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខ 1-888-254-2721។ (TTY/TDD: 711)

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

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਕੇ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸ਼ੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸਾਇੰ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਿਖਿਆ ਹੋਇਆ ਵੱਖੀ ਪਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੋਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

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

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

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

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or

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online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



REEP Benefits – HMO Rx Plan 2

The following outline of your group's outpatient prescription drug benefit is provided for your information. This document contains specific coverage and exclusion information related to your prescription benefit provided by REEP and administered by Express Scripts, Inc. For more information about these drugs or others, you can reach us by calling 1-888-806-4969 or by going to express-scripts.com. Just click on "Member Services" and login using your member ID. For more general information about drugs, vitamins and your health conditions, log on to express-scripts.com and select "Drug Digest".

Benefit Design	
Retail Copayments -30 Day Supply	
Generic	\$10
Formulary Brand	\$30
Non Formulary Brand	\$60
Mail Service Copayments – 90 Day Supply	
Generic	\$20
Formulary Brand	\$60
Non Formulary Brand	\$120

*** Healthcare Reform preventative items will be covered for a \$0 copay.*

*** Claims for Out-of-Network purchases will be reimbursed at 50%.*

*** Annual Out of Pocket \$1000 Individual / \$3000 Family*

Select Home Delivery Program – This Home Delivery program will encourage you to **take action** about where you purchase your maintenance medications. If you don't take any action, your copayment may increase. The program is designed to remind you of the benefits and potential savings through the Express Home Delivery pharmacy. You can call Express Scripts' **Member Choice Center at 877/603-1032** to review your options with a specialist; 1) You can either transfer your prescriptions to Home Delivery, or 2) **opt out** of the program.

Express Advantage Network - Certain pharmacies in the Express Scripts Network are identified as preferred pharmacies (Tier 1). Non-preferred pharmacies are in Tier 2. When you fill your prescriptions at a preferred Tier 1 pharmacy, you will pay the copay as outlined for your plan. *But, if you choose to use a Tier 2 pharmacy, you may pay up to an **additional \$15 plus your copay for each prescription** you fill at a non-preferred pharmacy.* Some examples of preferred Tier 1 pharmacies include (but are not limited to) Rite Aid, Stater Bros., Albertsons, Vons, Costco, Target, Sam's Club and Walmart.

Other Programs will remain in place and include;

Generics Preferred - If you - OR - Doctor select a brand drug when a generic drug is available you will pay the brand copay plus the difference in cost between the brand and generic. Your doctor must provide medical necessity to override the additional cost.

Accredo Exclusive Specialty Program - All specialty medications must go through the Accredo Pharmacy after one fill at retail. Please call 1-800-803-2523 if you are on a specialty injectable medication or specialty drug.

All prescription medications are covered by your plan. However some prescription products are excluded under your plan and are noted below.

<ul style="list-style-type: none"> ▪ All over-the-counter products & drugs, and over the counter equivalents** ▪ Serums, Toxoids, Vaccines ▪ Depigmentation agents and Injectable Cosmetic agents ▪ Durable Medical Equipment ▪ Drugs used for investigational purposes, or for off-label use ▪ Diagnostic, Testing and Imaging Supplies 	<ul style="list-style-type: none"> ▪ Homeopathic Medications and Medical Foods ▪ Fertility Agents ▪ Hair Growth Agents ▪ Contraceptive Devices, Implants, and IUDs ▪ Injectable Drugs to treat impotency (Yohimbine) ▪ Allergens ▪ Unit dose packaging, or repackaged products
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The following OTC drugs are covered: Diabetic Supplies, Peak Flow Meters, Non Insulin Syringes, and Respiratory Therapy Supplies

*Certain Injectable medications are not covered. ** Please call 1-888-806-4969 if you have a question on a drug that is not outlined or visit our website at express-scripts.com.

Prior Authorization & Step Therapy

Prior authorization is needed for certain medications. If you have questions on a particular drug, please contact Customer Service or visit express-scripts.com to perform a coverage check. Please have your doctor call Express Scripts at 1-800-753-2851 to go through a clinical review on your medication if it is subject to prior authorization.

Prior Authorization is a program that helps you get the prescription drugs you need ***with safety, savings and — most importantly — your good health in mind.*** It helps you get the most from your healthcare dollars with ***prescription drugs that work well for you and that are covered by your pharmacy benefit.*** It also helps control the rising cost of prescription drugs for everyone in your plan.

The program monitors certain prescription drugs to ensure that you are getting the appropriate drugs for your disease state. It works much like healthcare plans that approve certain medical procedures before they're done, to make sure you're getting tests you need: If you're prescribed a certain medication, that drug may need a "prior authorization." ***It makes sure you're getting a cost-effective drug that works for you.*** For instance, prior authorization ensures that covered drugs are used for treating medical problems rather than for other purposes.

Drug Quantity Limits

The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied for each copayment are consistent with clinical dosing guidelines as recommended by the Food & Drug Administration (FDA). The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care. Express Scripts clinicians maintain a list of quantity limit drugs, which is based upon manufacturer-recommended guidelines and medical literature. Online edits help make sure optimal quantities of medication are dispensed per copayment and per days' supply.

Express Scripts Home Delivery Pharmacy PO Box 66567 St Louis, Mo	Express Scripts Customer Service 1-888-806-4969 Open 24 hours, 365 days a year	Express Scripts Website www.express-scripts.com
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