

# Your summary of benefits



Anthem® Blue Cross

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

Your Network: Select HMO

| Covered Medical Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Cost if you use an In-Network Provider            | Cost if you use a Non-Network Provider |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------|
| <b>Overall Deductible</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | \$500 person /<br>\$1,000 family                  | Not covered                            |
| <b>Out-of-Pocket Limit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$1,500 single /<br>\$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> |                                                   |                                        |
| <b>Preventive Care / Screening / Immunization</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | No charge                                         | Not covered                            |
| <b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                   | No charge                                         | Not covered                            |
| <b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                   |                                        |
| <b>Virtual Visits - Online visits with Doctors who also provide services in person</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                   |                                        |
| Primary Care (PCP)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$40 copay per visit<br>deductible does not apply | Not covered                            |
| Mental Health and Substance Use Disorder care                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | No charge                                         | Not covered                            |
| Specialist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$40 copay per visit<br>deductible does not apply | Not covered                            |
| <b>Virtual Visits from Online Provider LiveHealth Online</b> <i>via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a>; 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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CA/LG/ REEP - Combined: Custom Value Deductible HMO \$500 40/0 0% (HMO 40 Chiro)/0UW1/07-01-2022

| 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<br>deductible does not apply   | Not covered                            |
| <b><u>Visits in an Office</u></b>                                                                                                           |                                                     |                                        |
| Primary Care (PCP)                                                                                                                          | \$40 copay per visit<br>deductible does not apply   | Not covered                            |
| Specialist Care                                                                                                                             | \$40 copay per visit<br>deductible does not apply   | Not covered                            |
| <b><u>Other Practitioner Visits</u></b>                                                                                                     |                                                     |                                        |
| Routine Maternity Care (Prenatal and Postnatal)                                                                                             | \$40 copay per visit<br>deductible does not apply   | Not covered                            |
| Retail Health Clinic                                                                                                                        | \$40 copay per visit<br>deductible does not apply   | Not covered                            |
| Chiropractic Care Rider<br><i>Coverage is limited to 30 visits per benefit period. Benefit limit is for office and outpatient combined.</i> | \$10 copay per visit<br>deductible does not apply   | Not covered                            |
| Acupuncture                                                                                                                                 | \$40 copay per visit<br>deductible does not apply   | Not covered                            |
| <b><u>Other Services in an Office</u></b>                                                                                                   |                                                     |                                        |
| 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<br>deductible does not apply | Not covered                            |

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

| Covered Medical Benefits                                                                                                                                                                           | Cost if you use an In-Network Provider            | Cost if you use a Non-Network Provider |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------|
| <b><u>Outpatient Mental Health and Substance Use Disorder</u></b>                                                                                                                                  |                                                   |                                        |
| <b>Doctor Office Visit</b>                                                                                                                                                                         | No charge                                         | Not covered                            |
| <b>Facility Visit</b>                                                                                                                                                                              |                                                   |                                        |
| Facility Fees                                                                                                                                                                                      | 0% coinsurance after deductible is met            | Not covered                            |
| Doctor Services                                                                                                                                                                                    | No charge                                         | Not covered                            |
| <b><u>Outpatient Surgery</u></b>                                                                                                                                                                   |                                                   |                                        |
| <b>Facility Fees</b>                                                                                                                                                                               |                                                   |                                        |
| Hospital                                                                                                                                                                                           | \$250 copay per visit after deductible is met     | Not covered                            |
| Freestanding Surgical Center                                                                                                                                                                       | \$250 copay per visit after deductible is met     | Not covered                            |
| <b>Doctor and Other Services</b>                                                                                                                                                                   |                                                   |                                        |
| Hospital                                                                                                                                                                                           | No charge                                         | Not covered                            |
| <b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u></b>                                                                                                             |                                                   |                                        |
| <b>Facility Fees</b>                                                                                                                                                                               | \$250 copay per admission after deductible is met | Not covered                            |
| <b>Doctor and other services</b>                                                                                                                                                                   | No charge                                         | Not covered                            |
| <b><u>Recovery &amp; Rehabilitation</u></b>                                                                                                                                                        |                                                   |                                        |
| <b>Home Health Care</b><br><i>Coverage is limited to 100 visits per benefit period.</i>                                                                                                            | No charge                                         | Not covered                            |
| <b>Rehabilitation services</b><br><i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy 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 |
|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------|
| <b>Cardiac rehabilitation</b><br><i>Coverage is limited to 36 visits per benefit period.</i><br>Office<br><br>Outpatient Hospital | \$40 copay per visit<br>deductible does not apply<br><br>0% coinsurance after deductible is met | Not covered<br><br>Not covered         |
| <b>Skilled Nursing Care (facility)</b><br><i>Coverage is limited to 100 days per benefit period.</i>                              | 0% coinsurance after deductible is met                                                          | Not covered                            |
| <b>Inpatient Hospice</b>                                                                                                          | 0% coinsurance after deductible is met                                                          | Not covered                            |
| <b>Durable Medical Equipment</b>                                                                                                  | 0% coinsurance after deductible is met                                                          | Not covered                            |
| <b>Prosthetic Devices</b>                                                                                                         | 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 |
|-------------------------------------------|----------------------------------------|----------------------------------------|
| <b>Pharmacy Deductible</b>                | Not covered                            | Not covered                            |
| <b>Pharmacy Out-of-Pocket Limit</b>       | Not covered                            | Not covered                            |
| <b>Prescription Drug Coverage</b>         |                                        |                                        |
| <b>Home Delivery Pharmacy</b>             |                                        |                                        |
| <b>Tier 1 - Typically Generic</b>         | Not covered (retail and home delivery) | Not covered (retail and home delivery) |
| <b>Tier 2 – Typically Preferred Brand</b> | 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 |
|---------------------------------------------------------|----------------------------------------|----------------------------------------|
| <b>Tier 3 - Typically Non-Preferred Brand</b>           | Not covered (retail and home delivery) | Not covered (retail and home delivery) |
| <b>Tier 4 - Typically Specialty (brand and generic)</b> | 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

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

### Chinese

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

### Farsi

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

### Hindi

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

### Hmong

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

### Japanese

**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)

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**Khmer**  
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យមនុស្សម្នាក់អានជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសេរីដោយសារតែអ្នកផងដែរ។ 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 ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸਾਇੰਸ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੱਖੀ ਪੜ੍ਹਾ ਪਾ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

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

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

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

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

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

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

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