Your summary of benefits

Anthem®

Anthem® Blue Cross

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

Your Network: Select 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	$40 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider
Overall Deductible	$500 person / $1,000 family
Overall Out-of-Pocket Limit	$1,500 single / $4,500 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, 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 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 single 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 single out-of-pocket limit. All medical deductibles, copayments and coinsurance apply to the 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) *virtual and office*	$40 copay per visit deductible does not apply
Mental Health and Substance Use Disorder Services *virtual and office*	No charge
Specialist Care *virtual and office*	$40 copay per visit deductible does not apply
Other Practitioner Visits	
Maternity services	
Prenatal and Postnatal care	$40 copay per visit deductible does not apply
Delivery	No charge after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$40 copay per visit deductible does not apply
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$10 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider
Acupuncture	$40 copay per visit deductible does not apply
Other Services in an Office	
Allergy Testing	No charge
Prescription Drugs *Dispensed in the office*	No charge
Surgery	$40 copay per surgery deductible does not apply
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 after deductible is met
X-Ray	
Office	No charge
Freestanding Radiology Center	No charge
Outpatient Hospital	No charge after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*	
Office	$40 copay per visit deductible does not apply
Freestanding Radiology Center	$40 copay per visit deductible does not apply
Outpatient Hospital	$40 copay per visit after deductible is met
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:** $40 copay per visit deductible does not apply
Emergency Room Facility Services *Your copay will be waived if admitted.*	**In-Network and Out-of-Network Providers:** $100 copay per visit deductible does not apply
Emergency Room Doctor and Other Services	**In-Network and Out-of-Network Providers:** No charge
Ambulance	**In-Network and Out-of-Network Providers:** No charge

Covered Medical Benefits	Cost if you use an In-Network Provider
Outpatient Mental Health and Substance Use Disorder Services at a Facility	
Facility Fees	No charge after deductible is met
Doctor Services	No charge
Outpatient Surgery	
Facility Fees	
Hospital	$250 copay per visit after deductible is met
Ambulatory Surgical Center	$250 copay per visit after deductible is met
Physician and other services *including surgeon fees*	
Hospital	No charge
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) *If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.*	
Facility Fees	$250 copay per admission after deductible is met
Physician and other services *including surgeon fees*	No charge
Home Health Care *Coverage is limited to 100 visits per benefit period.*	No charge
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and speech therapies is limited to 60 days combined per benefit period.*	
Office	No charge
Outpatient Hospital	No charge after deductible is met
Pulmonary rehabilitation	
Office	$40 copay per visit deductible does not apply
Outpatient Hospital	No charge after deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*	
Office	$40 copay per visit deductible does not apply
Outpatient Hospital	No charge after deductible is met
Dialysis/Hemodialysis	
Office	No charge
Outpatient Hospital	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider
Chemo/Radiation Therapy Office Outpatient Hospital	 No charge No charge after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 100 days per benefit period.*	No charge after deductible is met
Inpatient Hospice	No charge after deductible is met
Durable Medical Equipment	No charge after deductible is met
Prosthetic Devices	No charge 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 covered	Not covered
Pharmacy Out-of-Pocket Limit	Not covered	Not covered
Prescription Drug Coverage **Network:** **Drug List:**		
Day Supply Limits:		
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)
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:

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

REEP Benefits – HMO Rx Plan 4

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	$19
Formulary Brand	$50
Non-Formulary Brand	$75
Mail Service Copayments – 90 Day Supply	
Generic	$38
Formulary Brand	$100
Non-Formulary Brand	$150

*** 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 1-800-922-8279 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.

▪ All over-the-counter products & drugs, and over the counter equivalents** ▪ Serums, Toxoids - certain vaccines are covered ▪ Depigmentation agents and Injectable Cosmetic agents ▪ Durable Medical Equipment ▪ Drugs used for investigational purposes, of for off-label use ▪ Diagnostic, Testing and Imaging Supplies	▪ 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

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