Your summary of benefits

Anthem

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: REEP – Combined: Modified Anthem Elements Choice PPO 5900

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	$35 copay per visit for the first 3 visits and then No charge 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	$5,900 person / $11,800 family	$11,800 person / $23,600 family
Overall Out-of-Pocket Limit	$6,100 person / $12,200 family	$12,700 person / $25,400 family
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 out-of-pocket limit. In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate 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* *All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then No charge after deductible is met	50% coinsurance after deductible is met
Specialist Care *virtual and office* *All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then No charge after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits		
Maternity services		
Prenatal and Postnatal care *All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then No charge after deductible is met	50% 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
Delivery	No charge after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* *All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then No charge after deductible is met	50% coinsurance after deductible is met
Manipulation Therapy *Coverage for rehabilitative and habilitative physical therapy, occupational therapy and manipulative treatment is limited to 24 visits combined per benefit period. All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then No charge after deductible is met	50% coinsurance after deductible is met
Acupuncture *Coverage is limited to 12 visits per benefit period. All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then No charge after deductible is met	50% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	No charge after deductible is met	50% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	No charge after deductible is met	50% coinsurance after deductible is met
Surgery	No charge after deductible is met	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	No charge after deductible is met	50% coinsurance after deductible is met
Freestanding Lab	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
X-Ray		
Office	No charge after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% 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
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	No charge after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	No charge after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	No charge after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge after deductible is met	Covered as In-Network
Ambulance	No charge after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge after deductible is met	50% coinsurance after deductible is met
Doctor Services	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	No charge after deductible is met	50% 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	No charge after deductible is met	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*	No charge after deductible is met	50% 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
Home Health Care *Coverage is limited to 100 visits per benefit period.*	No charge after deductible is met	50% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and manipulative treatment is limited to 24 visits combined per benefit period. All office visit copayments count towards the same 3 visit limit.*		
Office	$35 copay per visit for the first 3 visits and then No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation *All office visit copayments count towards the same 3 visit limit.*		
Office	$35 copay per visit for the first 3 visits and then No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period. All office visit copayments count towards the same 3 visit limit.*		
Office	$35 copay per visit for the first 3 visits and then No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	No charge after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	No charge after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 100 days per benefit period.*	No charge after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	20% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	No charge after deductible is met	50% 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 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.
- 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.

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: (866) 837-4388 or visit us at www.anthem.com/ca