# Your summary of benefits

Anthem

Anthem® Blue Cross

Your Plan: REEP - Combined: Custom Premier HMO 30/100

Your Network: California Care 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** | $30 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Overall Deductible** | $0 person |
| **Overall Out-of-Pocket Limit** | $500 single /<br>$1,500 family |
| To get benefits under this Plan, you must use In-Network Providers. **Services from Non-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.<br>The family out-of-pocket limit is embedded, meaning each covered person is capped at his or her per single out-of-pocket limit; in addition, cost shares for all covered family members apply to the family out-of-pocket limit, yet no one member will pay more than the per single out-of-pocket limit.<br>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* | $30 copay per visit |
| **Mental Health and Substance Use Disorder Services** *virtual and office* | No charge |
| **Specialist Care** *virtual and office* | $30 copay per visit |
| **Other Practitioner Visits** | |
| **Routine Maternity Care** (Prenatal and Postnatal) | $30 copay per visit |
| **Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | $30 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Manipulation Therapy**<br>*Coverage is limited to 30 visits per benefit period.* | $10 copay per visit |
| **Acupuncture** | $30 copay per visit |
| **Other Services in an Office** | |
| **Allergy Testing** | No charge |
| **Prescription Drugs** *Dispensed in the office* | No charge |
| **Surgery** | $30 copay per surgery |
| **Preventive care / screenings / immunizations** | No charge |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge |
| **Diagnostic Services**<br>**Lab** | |
| Office | No charge |
| Freestanding Lab | No charge |
| Outpatient Hospital | No charge |
| **X-Ray** | |
| Office | No charge |
| Freestanding Radiology Center | No charge |
| Outpatient Hospital | No charge |
| **Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | |
| Office | $30 copay per service |
| Freestanding Radiology Center | $30 copay per service |
| Outpatient Hospital | $30 copay per service |
| **Emergency and Urgent Care** | |
| **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.* | **In-Network and Non-Network Providers:**<br>$30 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Emergency Room Facility Services**<br>*Your copay will be waived if admitted.* | **In-Network and Non-Network Providers:**<br>$100 copay per visit |
| **Emergency Room Doctor and Other Services** | **In-Network and Non-Network Providers:**<br>No charge |
| **Ambulance** | **In-Network and Non-Network Providers:**<br>No charge |
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | |
| Facility Fees | No charge |
| Doctor Services | No charge |
| **Outpatient Surgery** | |
| **Facility Fees** | |
| Hospital | No charge |
| Ambulatory Surgical Center | No charge |
| **Physician and other services** *including surgeon fees* | |
| Hospital | No charge |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)** | |
| **Facility Fees** | No charge |
| **Physician and other services** *including surgeon fees* | No charge |
| **Home Health Care**<br>*Coverage is limited to 100 visits per benefit period.* | No charge |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.*<br>*Coverage for physical, occupational and speech therapies is limited to 60 days combined per benefit period.* | |
| Office | No charge |
| Outpatient Hospital | No charge |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Pulmonary rehabilitation** *office and outpatient hospital* | $30 copay per visit |
| **Cardiac rehabilitation** *office and outpatient hospital*<br>*Coverage is limited to 36 visits per benefit period.* | $30 copay per visit |
| **Dialysis/Hemodialysis** *office and outpatient hospital* | No charge |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | No charge |
| **Skilled Nursing Care (facility)**<br>*Coverage is limited to 100 days per benefit period.* | No charge |
| **Inpatient Hospice** | No charge |
| **Durable Medical Equipment** | No charge |
| **Prosthetic Devices** | No charge |

| 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**<br>**Network:**<br>**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) |

| 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:**

- 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

Anthem

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# 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 بالرقم1-888-254-2721 (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

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 យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 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 ਤੁਸ□ ਇਹ ਪੱਤਰ ਪੜਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹ□, ਤਾਂ ਅਸ□ ਇਸ ਨੂੰ ਪੜਹ੍ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ□ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਖਆ ਹੋਇਆ ਵਬੀ ਪਰ੍ਾਪ ੍ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੈਰਨ 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 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 3

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 | $15 |
| Formulary Brand | $40 |
| Non Formulary Brand | $80 |
| **Mail Service Copayments – 90 Day Supply** | |
| Generic | $30 |
| Formulary Brand | $80 |
| Non Formulary Brand | $160 |

*** 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.**

| | |
|---|---|
| ▪ All over-the-counter products & drugs, and over the counter equivalents**<br>▪ Serums, Toxoids, Vaccines<br>▪ Depigmentation agents and Injectable Cosmetic agents<br>▪ Durable Medical Equipment<br>▪ Drugs used for investigational purposes, of for off-label use<br>▪ Diagnostic, Testing and Imaging Supplies | ▪ Homeopathic Medications and Medical Foods<br>▪ Fertility Agents<br>▪ Hair Growth Agents<br>▪ Contraceptive Devices, Implants, and IUDs<br>▪ Injectable Drugs to treat impotency (Yohimbine)<br>▪ Allergens<br>▪ 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 | Express Scripts Customer Service | Express Scripts Website |
|---|---|---|
| PO Box 66567<br>St Louis, Mo | **1-888-806-4969**<br>Open 24 hours, 365 days a year | www.express-scripts.com |