

Your summary of benefits



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 <i>virtual and office</i> <i>All office visit copayments count towards the same 3 visit limit.</i>	\$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 <i>virtual and office</i> <i>All office visit copayments count towards the same 3 visit limit.</i>	\$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
<p>Delivery</p> <p>Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i> <i>All office visit copayments count towards the same 3 visit limit.</i></p> <p>Manipulation Therapy <i>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.</i></p> <p>Acupuncture <i>Coverage is limited to 12 visits per benefit period. All office visit copayments count towards the same 3 visit limit.</i></p>	<p>No charge after deductible is met</p> <p>\$35 copay per visit for the first 3 visits and then No charge after deductible is met</p> <p>\$35 copay per visit for the first 3 visits and then No charge after deductible is met</p> <p>\$35 copay per visit for the first 3 visits and then No charge after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	50% coinsurance after deductible is met
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>X-Ray</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	No charge after deductible is met No charge after deductible is met No charge after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i> Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance	No charge after deductible is met No charge after deductible is met No charge after deductible is met No charge after deductible is met	50% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility Facility Fees Doctor Services	No charge after deductible is met No charge after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> Hospital	No charge after deductible is met No charge after deductible is met No charge after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> <i>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.</i> Facility Fees Physician and other services <i>including surgeon fees</i>	No charge after deductible is met No charge after deductible is met	50% coinsurance 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 <i>Coverage is limited to 100 visits per benefit period.</i>	No charge after deductible is met	50% coinsurance after deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>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.</i> Office Outpatient Hospital	\$35 copay per visit for the first 3 visits and then No charge after deductible is met No charge after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Pulmonary rehabilitation <i>All office visit copayments count towards the same 3 visit limit.</i> Office Outpatient Hospital	\$35 copay per visit for the first 3 visits and then No charge after deductible is met No charge after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period. All office visit copayments count towards the same 3 visit limit.</i> Office Outpatient Hospital	\$35 copay per visit for the first 3 visits and then No charge after deductible is met No charge after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	No charge after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	No charge after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	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.

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



REEP Benefits – PPO 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 \$500 Individual / \$1000 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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