Your summary of benefits

Anthem®

Anthem® Blue Cross

Your 2027 Contract Code: 1GQT

Your Plan: Anthem Gold Priority Select HMO 35/500/20%

Your Network: Small Group Priority Select HMO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, services received in an office, Ambulatory Surgical Center, or outpatient facility are combined across all outpatient settings. 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 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.

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	$55 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$500 person / $1,500 family	Not covered
Overall Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.*	$10,000 person / $20,000 family	Not covered
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member 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 member deductible or per member out-of-pocket limit. *Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for the following service(s) do not apply toward the out-of-pocket limit: adult vision.*		
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.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$35 copay per visit medical deductible does not apply	Not covered
Specialist Provider *virtual and office*	$55 copay per visit medical deductible does not apply	Not covered
Other Practitioner Visits		
Maternity Doctor services		
Prenatal care	No charge	Not covered
Delivery	No charge	Not covered
Postpartum care	$35 copay per visit medical deductible does not apply	Not covered
Retail Health Clinic Visit	$35 copay per visit medical deductible does not apply	Not covered
Chiropractic/Manipulation Therapy *Coverage is limited to 30 visits per year.*	$15 copay per visit medical deductible does not apply	Not covered
Acupuncture	$35 copay per visit medical deductible does not apply	Not covered
Other Services in an Office		
Allergy Testing	$35 copay per visit medical deductible does not apply	Not covered
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection. Maximum of $250 member cost share per drug.*	20% coinsurance medical deductible does not apply	Not covered
Surgery	$55 copay per surgery medical deductible does not apply	Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services Lab		
Office	$15 copay per visit medical deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Freestanding Lab/Reference Lab	$15 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Diagnostic Services X-Ray		
Office	$15 copay per visit medical deductible does not apply	Not covered
Freestanding Radiology Center	$15 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Diagnostic Services Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans		
Office	$200 copay per day medical deductible does not apply	Not covered
Freestanding Radiology Center	$200 copay per day medical deductible does not apply	Not covered
Outpatient Hospital	$350 copay per day after medical deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care (Office Setting)	$35 copay per visit medical deductible does not apply	Covered as In-Network
Emergency Room Facility Services *Your copay will be waived if admitted.*	$500 copay per visit and 20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance Transportation	20% coinsurance after medical deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge	Not covered
Doctor Services	No charge	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	Not covered
Ambulatory Surgical Center	$500 copay per visit after medical deductible is met	Not covered
Physician and other services including surgeon fees		
Hospital	No charge	Not covered
Ambulatory Surgical Center	No charge	Not covered
Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)		
Facility fees (for example, room & board) *Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period.*	20% coinsurance after medical deductible is met	Not covered
Physician and other services including surgeon fees	No charge	Not covered
Home Health Care *Home health visits are limited to 100 visits per benefit period. Benefit limit does not apply to physical, occupational or speech therapy when performed as part of Home Health. Limits are combined for home health care and private duty nursing.*	$55 copay per visit medical deductible does not apply	Not covered
Therapy Services		
Rehabilitation services (for example, physical/speech/occupational therapy)		
Office	$35 copay per visit medical deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Habilitation services (for example, physical/speech/occupational therapy)		
Office	$35 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Pulmonary rehabilitation		
Office	$35 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Cardiac rehabilitation		
Office	$35 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Dialysis/Hemodialysis		
Office	20% coinsurance medical deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Chemo/Radiation Therapy		
Office	20% coinsurance medical deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Skilled Nursing Care (in a facility) *Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period.*	20% coinsurance after medical deductible is met	Not covered
Inpatient Hospice	No charge after medical deductible is met	Not covered
Durable Medical Equipment	50% coinsurance after medical deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Not covered
<u>Prescription Drug Coverage</u> **Network:** ***Rx Choice Tiered Network*** **Drug List:** ***Select*** *Drugs not included on the Select drug list will not be covered. Prescription Drugs that we are required to cover by federal law under the "Preventive Care" benefit will be covered with no deductible, copayments or coinsurance when you use an In-Network Pharmacy.* ***For more information, refer to "Select Drug List" at*** *https://www.anthem.com/ca/pharmacy-information/*.			
<u>Day Supply Limits</u> **Retail Pharmacy:** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy:** *90 day supply (cost shares noted below)* **Home Delivery Pharmacy:** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy:** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*			
Tier 1 - Typically Generic *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.*	$20 copay per prescription (retail) and $40 copay per prescription (home delivery)	$30 copay per prescription (retail only)	Not covered (retail and home delivery)
Tier 2 - Typically Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.*	$50 copay per prescription (retail) and $125 copay per prescription (home delivery)	$60 copay per prescription (retail only)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.*	$90 copay per prescription (retail) and $225 copay per prescription (home delivery)	$100 copay per prescription (retail only)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to $250 per prescription (retail and home delivery)	40% coinsurance up to $250 per prescription (retail only)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	Not applicable	Not applicable
Vision Exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	No charge	Not covered
Frames *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Single Vision Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Bifocal Vision Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Trifocal Vision Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Elective Contact Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Non-Elective Contact Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not applicable	Not applicable
Vision Exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	No charge	Not covered
Frames	Not covered	Not covered
Single Vision Lenses	Not covered	Not covered
Bifocal Vision Lenses	Not covered	Not covered
Trifocal Vision Lenses	Not covered	Not covered
Elective Contact Lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out-of-pocket limit.		
Children's Dental Essential Health Benefits		
Diagnostic and preventive *Coverage for In-Network Providers is limited to 1 visit per 6 months.*	No charge	Not covered
Basic services	20% coinsurance dental deductible does not apply	Not covered
Major services	50% coinsurance dental deductible does not apply	Not covered
Medically Necessary Orthodontia services	50% coinsurance dental deductible does not apply	Not covered
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	$0	Not covered
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	Not covered

Notes:

- The representation of benefits in this document is subject to state and federal regulatory approvals and are subject to change.
- Benefit period refers to calendar year.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If services are rendered by a non-participating provider and your plan includes Out-of-Network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider's charge.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- 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.
- Certain services are subject to the utilization review program or precertification. Before scheduling services, the member must make sure utilization or precertification review is obtained. If utilization or precertification review is not obtained, benefits may be reduced or not paid according to the plan.
- 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 health plan includes an Employee Assistance Program (EAP) to support your emotional health and wellness with work life resources, including one-on-one counseling by phone, in person and online. Three counseling visits are available at no charge to a member. EAP member service is accessible 24/7/365.

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Questions: (833) 913-2234 or visit us at www.anthem.com/ca

CA/SG/Anthem Gold Priority Select HMO 35/500/20%/1GQT/2027

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 with translations or interpreter services, in a timely manner, please call the telephone number on the back of your ID card. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative 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? Si no es así, podemos pedirle a alguien que lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda oportuna y gratuita con traducciones o servicios de interpretación, llame al número de teléfono que figura en el dorso de su tarjeta de identificación. (TTY/TDD: 711).

Arabic

هام: هل يمكنك قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، فيمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية في خدمات الترجمة أو الترجمة الفورية، في الوقت المناسب، يرجى الاتصال برقم الهاتف الموجود على ظهر بطاقة الهوية الخاصة بك. (TTY/TDD:711).

Armenian

ԿԱՐԵՎՈՐ Է. կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, կարող ենք օգնել ձեզ կարդալ այն: Դուք կարող եք նաև ստանալ այս նամակը գրավոր՝ ձեր լեզվով: Թարգմանությունների կամ թարգմանչական ծառայությունների անվճար օգնության համար, ժամանակին, խնդրում ենք զանգահարել ձեր ID քարտի հակառակ կողմում նշված հեռախոսահամարով: (TTY/TDD՝ 711):

Chinese

重要提示：您能讀懂這封信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需及時獲得免費的翻譯或口譯服務協助，請撥打您 ID 卡背面的電話號碼。(TTY/TDD:711)。

Farsi

مهم: می‌توانید این نامه را بخوانید؟ اگر نه، می‌توانیم از کسی بخواهیم که در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان و به‌موقع در زمینه خدمات ترجمه کتبی یا مترجم شفاهی، لطفاً با شماره تلفن مندرج در پشت کارت ID خود تماس بگیرید. (TTY/TDD:711).

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम किसी को इसे पढ़ने में आपकी सहायता करने के लिए रख सकते हैं। आप इस पत्र को अपनी भाषा में भी लिखवा सकते हैं। अनुवाद या दुभाषिया सेवाओं के संबंध में समय पर निःशुल्क सहायता के लिए कृपया अपने पहचान पत्र के पीछे दिए गए टेलीफोन नंबर पर कॉल करें। (TTY/TDD:711)।

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Hmong
TSEEM CEEB: Koj puas yeem nyeem tau tsab ntawv no? Yog tias nyeem tsis tau, peb mam kom lwm tus neeg los pab nyeem rau koj. Koj hais tau kom muab tsab ntawv no sau ua koj yam lus. Rau kev pab txhais ntawv los sis txhais lus pab dawb, kom raws sij hawm, thov hu tus npawb xov tooj nyob sab nraum qab ntawm koj daim npav ID. (TTY/TDD: 711).

Japanese
重要：この手紙は読めますか？そうでない場合は、誰かに読んでもらうのを手伝ってもらうこともできます。このお知らせは、貴方の言語で受け取ることも可能です。翻訳や通訳サービスの無料サポートをご希望の場合は、ID カードの裏面に記載されている電話番号までお電話ください。(TTY/TDD:711)。

Khmer
សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអ្នកឱ្យអានវាបាន។ អ្នកក៏ប្រហែលជាអាចឱ្យសំបុត្រនេះសរសេរជាភាសារបស់អ្នកបានផងដែរ។ ដើម្បីទទួលបានជំនួយដោយឥតគិតថ្លៃជាមួយនឹងការបកប្រែឬសេវាអ្នកបកប្រែផ្ទាល់មាត់ទាន់ពេលវេលា សូមទូរស័ព្ទទៅលេខនៅខាងក្រោយកាត ID របស់អ្នក។ (TTY/TDD:711)។

Korean
중요: 이 서신을 읽으실 수 있습니까? 그렇지 않다면 서신을 읽을 수 있게 도움을 드릴 수 있습니다. 원하시는 언어로 이 서신을 받으실 수도 있습니다. 번역이나 통역 서비스를 무료로 이용하시려면 적시에 ID 카드 뒷면에 있는 전화번호로 전화해 주십시오. (TTY/TDD: 711).

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਅਨੁਵਾਦ ਜਾਂ ਦੁਭਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਵਿੱਚ ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਸਮੇਂ ਸਿਰ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਟੈਲੀਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD:711).

Russian
ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Чтобы своевременно получить бесплатные услуги письменного или устного перевода, позвоните по номеру телефона, указанному на оборотной стороне вашей идентификационной карты участника. (TTY/TDD: 711).

Tagalog
MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maaari kaming kumuha ng taong tutulong sa iyo na basahin ito. Maaari mo ring ipasulat ang sulat na ito sa iyong wika. Para sa libreng tulong sa mga pagsasalin o serbisyo ng interpreter, sa isang napapanahong paraan, mangyaring tawagan ang numero ng telepono sa likod ng iyong ID card. (TTY/TDD:711).

Thai
ข้อสำคัญ: คุณสามารถอ่านจดหมายฉบับนี้ได้หรือไม่ ถ้าไม่ เราสามารถหาคนช่วยอ่านให้กับคุณได้ นอกจากนี้คุณยังสามารถขอให้เขียนจดหมายให้ได้ในภาษาของคุณเอง ขอรับบริการแปลหรือล่ามที่รวดเร็วได้ฟรี กรุณาติดต่อหมายเลขโทรศัพท์ที่ด้านหลังของบัตรประจำตัวของคุณ (TTY/TDD:711).

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc thư. Quý vị cũng có thể yêu cầu viết lá thư này bằng ngôn ngữ của mình. Để được trợ giúp miễn phí về dịch vụ biên dịch hoặc thông dịch một cách kịp thời, vui lòng gọi số điện thoại ở mặt sau thẻ ID của quý vị. (TTY/TDD: 711).

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