Your summary of benefits

Anthem® Blue Cross

Your Plan: Anthem Elements Choice HMO 1500 Priority Select HMO

Your Network: Priority 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 medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	$50 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider
Overall Deductible *Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.*	$1,500 person / $3,000 family
Overall Out-of-Pocket Limit	$6,400 single / $12,800 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. 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 and prescription drug 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) and Mental Health and Substance Use Disorder Services *virtual and office*	$25 copay per visit medical deductible does not apply
Specialist Care *virtual and office*	$50 copay per visit medical deductible does not apply
Other Practitioner Visits	
Routine Maternity Care (Prenatal and Postnatal)	$25 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$25 copay per visit medical deductible does not apply
Manipulation Therapy *Coverage is limited to 20 visits per benefit period.*	$25 copay per visit medical deductible does not apply
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$25 copay per visit medical deductible does not apply
Other Services in an Office	
Allergy Testing	$25 copay per visit medical deductible does not apply
Prescription Drugs *Dispensed in the office* *Maximum of $250 member cost share per drug.*	30% coinsurance medical deductible does not apply
Surgery	$25 copay per surgery medical 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	30% coinsurance after medical deductible is met
X-Ray	
Office	No charge
Freestanding Radiology Center	No charge
Outpatient Hospital	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*	
Office	$100 copay per service medical deductible does not apply
Freestanding Radiology Center	$100 copay per service medical deductible does not apply
Outpatient Hospital	$100 copay per service medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider
Emergency and Urgent Care	
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	**In-Network and Non-Network Providers:** $25 copay per visit medical deductible does not apply
Emergency Room Facility Services *Your copay will be waived if admitted.*	**In-Network and Non-Network Providers:** $250 copay per visit and 30% coinsurance after medical deductible is met
Emergency Room Doctor and Other Services	**In-Network and Non-Network Providers:** No charge
Ambulance *Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	**In-Network and Non-Network Providers:** $100 copay per trip medical deductible does not apply
Outpatient Mental Health and Substance Use Disorder Services at a Facility	
Facility Fees	No charge
Doctor Services	No charge
Outpatient Surgery	
Facility Fees	
Hospital	30% coinsurance after medical deductible is met
Ambulatory Surgical Center	30% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	
Hospital	No charge
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)	
Facility Fees	30% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	No charge
Home Health Care *Coverage is limited to 100 visits per benefit period.*	$25 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 40 visits combined per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.*	
Office	$25 copay per visit medical deductible does not apply
Outpatient Hospital	30% coinsurance after medical deductible is met
Pulmonary rehabilitation	
Office	$25 copay per visit medical deductible does not apply
Outpatient Hospital	30% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*	
Office	$25 copay per visit medical deductible does not apply
Outpatient Hospital	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	
Office	$50 copay per visit medical deductible does not apply
Outpatient Hospital	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	
Office	$50 copay per visit medical deductible does not apply
Outpatient Hospital	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	30% coinsurance after medical deductible is met
Inpatient Hospice	No charge
Durable Medical Equipment	20% coinsurance medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider
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	$500 person / $1,500 family (does not apply to Tier 1a, Tier 1b drugs)	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. 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 1a - Typically Lower Cost Generic	$5 copay per prescription, Pharmacy deductible does not apply (retail) and $10 copay per prescription, Pharmacy deductible does not apply (home delivery)	Not covered (retail and home delivery)
Tier 1b - Typically Generic	$20 copay per prescription, Pharmacy deductible does not apply (retail) and $40 copay per prescription, Pharmacy deductible does not apply (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	$50 copay per prescription after Pharmacy deductible is met (retail) and $125	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
	copay per prescription after Pharmacy deductible is met (home delivery)	
Tier 3 - Typically Non-Preferred Brand	$75 copay per prescription after Pharmacy deductible is met (retail) and $188 copay per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to $250 per prescription after Pharmacy deductible is met (retail and home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	Not covered
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	No charge	Not covered

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: (855) 333-5730 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 ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ□ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪਰ੍ਾਪ੍ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ 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: ท่านสามารถอ่านจดหมายฉบับนีหรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี เราสามารถจัดหาเจ้าหน้าทีมาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าทีช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อทีหมายเลข 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.