California
BENEFIT CHART

Anthem

Medical

Benefit Charts

2023 Individual and Family Plans

Plans off the Marketplace

Bronze, Silver, Gold, Platinum, and Minimum Coverage plans

EPO and HMO plans offered by Anthem Blue Cross

Open enrollment period runs November 1, 2022 - January 31, 2023

A02055CAMENABC 7/22

Helping you feel covered, protected, and confident

Whether you've had health coverage before or are new to this process, we're here to support you every step of the way—from helping you decide which individual plan makes sense for your unique needs to connecting you to the right doctor, resources, and financial help.

We're committed to simplifying and caring for every aspect of your health, including medical, dental, vision, pharmacy, and mental health needs.

The following pages contain plan benefit charts along with terms you need to know when selecting a health plan. This information will help you understand commonly used insurance words and assist you in selecting the right coverage for your needs and budget.

▷ Let us connect you to the right individual coverage.

Product Overview

Understanding Provider Networks

When choosing a plan, you will have access to a specific network. Certain networks may be larger than others or offer different options for local providers. It's important to understand these differences and keep your healthcare needs in mind when choosing a plan.

Exclusive provider organization (EPO):

With our EPO plans, you'll be able to see any in network doctor. It's a good idea to have a primary care doctor to coordinate your care, so we will pick one close to your home and let you know your assignment in the beginning of the year. You can also choose a primary care doctor. You do not need to see this doctor for services or referrals, and you can change your assigned primary care doctor at any time.

EPO plans do not offer out of network benefits, except for emergency and urgent care, ambulance services, or when a service is preapproved. If you see a doctor not in your plan for any other reason, you'll have to pay 100% out of pocket.

EPO plans are available in Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kern, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo, and Yuba counties.

Health maintenance organization (HMO):

With an HMO, you have to choose a primary care doctor to manage your care needs — including receiving referrals to see other network doctors. HMOs do not offer out of network benefits, except for emergency and urgent care, ambulance services, or when a service is preapproved. If you see a doctor not in your plan for any other reason, you'll have to pay 100% out of pocket.

HMO plans are available in Fresno, Kings, Los Angeles, Madera, Orange, Riverside, San Bernardino, and San Diego counties.

View our county network coverage map here.

Plan benefit charts — EPO

EPO plans only include out of network benefits for emergency care, urgent care, and ambulance services, or when a service is preapproved. The benefit information shown here is for in network services.

EPO plans are available in Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kern, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo, and Yuba counties.

Plan name	Anthem Bronze 60 D EPO (6R4V)	Anthem Bronze 60 D HDHP EPO (6R4G)	Anthem Silver 70 Off Exchange EPO (6R57)	Anthem Gold 80 D EPO (6R4H)	Anthem Platinum 90 D EPO (6R5K)	Anthem Minimum Coverage D EPO (6R5J)
Network name	Pathway - EPO	Pathway - EPO	Pathway - EPO	Pathway - EPO	Pathway - EPO	Pathway - EPO
Plan includes out of network coverage?	No	No	No	No	No	No
Individual deductible	$6,300	$7,000	$4,750	$0	$0	$9,100
Individual out-of-pocket maximum	$8,200	$7,000	$8,750	$8,550	$4,500	$9,100
Coinsurance (percentage may vary for certain covered services)	40%	0%	20%	20%	10%	0%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office (in person or online) visit: primary care physician (PCP)[2,3] (Other office services may be subject to deductible and plan coinsurance)	$65 copay per visit for first 3 visits, then deductible and $65 copay	Deductible, then covered in full	$45 copay, deductible waived	$35 copay, deductible waived	$15 copay, deductible waived	$0 copay per visit for first 3 visits, then deductible and 0% coinsurance
Online visit from our online provider: LiveHealth Online	Covered in full, deductible waived	Deductible, then covered in full	Covered in full, deductible waived	Covered in full, deductible waived	Covered in full, deductible waived	$0 copay per visit for first 3 visits, then deductible and 0% coinsurance
Office and online visit: specialist[3] (Other office services may be subject to deductible and plan coinsurance)	$95 copay per visit for first 3 visits, then deductible and $95 copay	Deductible, then covered in full	$85 copay, deductible waived	$65 copay, deductible waived	$30 copay, deductible waived	Deductible, then covered in full
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 40% coinsurance	Deductible, then covered in full	$95 copay, deductible waived	$75 copay, deductible waived	$30 copay, deductible waived	Deductible, then covered in full
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 40% coinsurance	Deductible, then covered in full	$325 copay, deductible waived	25% coinsurance, deductible waived	10% coinsurance, deductible waived	Deductible, then covered in full
Urgent care[3] (Other office services may be subject to deductible and plan coinsurance)	$65 copay per visit for first 3 visits, then deductible and $65 copay	Deductible, then covered in full	$45 copay, deductible waived	$35 copay, deductible waived	$15 copay, deductible waived	$0 copay per visit for first 3 visits, then deductible and 0% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 40% coinsurance	Deductible, then covered in full	$400 copay, deductible waived	$350 copay, deductible waived	$150 copay, deductible waived	Deductible, then covered in full
Hospital: inpatient admission (includes maternity, mental health/substance use)	Deductible, then 40% coinsurance	Deductible, then covered in full	Deductible, then 30% coinsurance	30% coinsurance, deductible waived	10% coinsurance, deductible waived	Deductible, then covered in full
Hospital: outpatient surgery hospital facility (includes maternity, mental health/substance use)	Deductible, then 40% coinsurance	Deductible, then covered in full	20% coinsurance, deductible waived	20% coinsurance, deductible waived	10% coinsurance, deductible waived	Deductible, then covered in full
Pharmacy deductible[4] (for tiers with deductible, cost share applies after deductible)	Tiers 1,2,3,4: $500/$1,000 Pharmacy deductible	Tiers 1,2,3,4: Medical deductible applies	Tiers 1,2,3,4: $85/$170 Pharmacy deductible	Tiers 1,2,3,4: No deductible	Tiers 1,2,3,4: No deductible	Tiers 1,2,3,4: Medical deductible applies
Retail pharmacy tier 1: Level 1 / Level 2	$18 copay	0% coinsurance	$16 copay	$15 copay	$5 copay	0% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	40% coinsurance (up to $500 per script)	0% coinsurance	$60 copay	$60 copay	$15 copay	0% coinsurance
Retail pharmacy tier 3: Level 1 / Level 2	40% coinsurance (up to $500 per script)	0% coinsurance	$90 copay	$85 copay	$25 copay	0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	40% coinsurance (up to $500 per script)	0% coinsurance	20% coinsurance (up to $250 per script)	20% coinsurance (up to $250 per script)	10% coinsurance (up to $250 per script)	0% coinsurance
Physical and occupational therapy	$65 copay, deductible waived	Deductible, then covered in full	$45 copay, deductible waived	$35 copay, deductible waived	$15 copay, deductible waived	Deductible, then covered in full
Speech therapy	$65 copay, deductible waived	Deductible, then covered in full	$45 copay, deductible waived	$35 copay, deductible waived	$15 copay, deductible waived	Deductible, then covered in full

Please see Medical plans footnotes on page 5.

Plan benefit charts

HMO plans only include out of network benefits for emergency care, urgent care, and ambulance services, or when a service is preapproved. The benefit information shown here is for in network services.

HMO plans are available in Fresno, Kings, Los Angeles (North), Los Angeles (South), Madera, Orange, Riverside, San Bernardino, and San Diego counties.

Plan name	Anthem Bronze 60 D HMO (6R5G)	Anthem Silver 70 Off Exchange HMO (6R5A)	Anthem Gold 80 D HMO (6R4D)	Anthem Platinum 90 D HMO (6R5L)	Anthem Minimum Coverage D HMO (6R5E)
Network name	Pathway - HMO	Pathway - HMO	Pathway - HMO	Pathway - HMO	Pathway - HMO
Plan includes out of network coverage?	No	No	No	No	No
Individual deductible	$6,300	$4,750	$0	$0	$9,100
Individual out-of-pocket maximum	$8,200	$8,750	$8,550	$4,500	$9,100
Coinsurance (percentage may vary for certain covered services)	40%	20%	20%	10%	0%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office (in person or online) visit: primary care physician (PCP)[2,3] (Other office services may be subject to deductible and plan coinsurance)	$65 copay per visit for first 3 visits, then deductible and $65 copay	$45 copay, deductible waived	$35 copay, deductible waived	$15 copay, deductible waived	$0 copay per visit for first 3 visits, then deductible and 0% coinsurance
Online visit from our online provider: LiveHealth Online	Covered in full, deductible waived	Covered in full, deductible waived	Covered in full, deductible waived	Covered in full, deductible waived	$0 copay per visit for first 3 visits, then deductible and 0% coinsurance
Office and online visit: specialist[3] (Other office services may be subject to deductible and plan coinsurance)	$95 copay per visit for first 3 visits, then deductible and $95 copay	$85 copay, deductible waived	$65 copay, deductible waived	$30 copay, deductible waived	Deductible, then covered in full
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 40% coinsurance	$95 copay, deductible waived	$75 copay, deductible waived	$30 copay, deductible waived	Deductible, then covered in full
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 40% coinsurance	$325 copay, deductible waived	$75 copay, deductible waived	$75 copay, deductible waived	Deductible, then covered in full
Urgent care[3] (Other office services may be subject to deductible and plan coinsurance)	$65 copay per visit for first 3 visits, then deductible and $65 copay	$45 copay, deductible waived	$35 copay, deductible waived	$15 copay, deductible waived	$0 copay per visit for first 3 visits, then deductible and 0% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 40% coinsurance	$400 copay, deductible waived	$350 copay, deductible waived	$150 copay, deductible waived	Deductible, then covered in full
Hospital: inpatient admission (includes maternity, mental health/substance use)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	$350 copay per day up to 5 days per admission	$250 copay per day up to 5 days per admission	Deductible, then covered in full
Hospital: outpatient surgery hospital facility (includes maternity, mental health/substance use)	Deductible, then 40% coinsurance	20% coinsurance, deductible waived	$150 copay, deductible waived	$100 copay, deductible waived	Deductible, then covered in full
Pharmacy deductible[4] (for tiers with deductible, cost share applies after deductible)	Tiers 1,2,3,4: $500/$1,000 Pharmacy deductible	Tiers 1,2,3,4: $85/$170 Pharmacy deductible	Tiers 1,2,3,4: No deductible	Tiers 1,2,3,4: No deductible	Tiers 1,2,3,4: Medical deductible applies
Retail pharmacy tier 1: Level 1 / Level 2	$18 copay	$16 copay	$15 copay	$5 copay	0% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	40% coinsurance (up to $500 per script)	$60 copay	$60 copay	$15 copay	0% coinsurance
Retail pharmacy tier 3: Level 1 / Level 2	40% coinsurance (up to $500 per script)	$90 copay	$85 copay	$25 copay	0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	40% coinsurance (up to $500 per script)	20% coinsurance (up to $250 per script)	20% coinsurance (up to $250 per script)	10% coinsurance (up to $250 per script)	0% coinsurance
Physical and occupational therapy	$65 copay, deductible waived	$45 copay, deductible waived	$35 copay, deductible waived	$15 copay, deductible waived	Deductible, then covered in full
Speech therapy	$65 copay, deductible waived	$45 copay, deductible waived	$35 copay, deductible waived	$15 copay, deductible waived	Deductible, then covered in full

Please see Medical plans footnotes on page 5.

Medical plans footnotes

1 Nationally recommended **preventive care services** from in network providers have no copay, no coinsurance, and no deductible requirement. Preventive and wellness services consist of certain services, including well-child care, immunizations, prostate-specific antigen (PSA) screenings, Pap tests, and mammograms, as recommended by the United States Preventive Services Task Force.

2 **LiveHealth Online** primary care visits are at no cost when enrolled in one of the following plans: Bronze (non-HDHP), Silver, Gold, and Platinum plans.

3 With plans that have **PCP, specialist** and **urgent care** office visit limits, the visit limits are combined, not separate.

4 With plans that have a **pharmacy deductible**, the pharmacy deductible is separate from the medical deductible. The family deductible is two (2) times the individual amount.

Terms you need to know

Coinsurance: Your percentage of healthcare costs after your deductible has been paid.

Copay: The set dollar amount you pay for covered services, such as doctor visits.

Deductible: The set dollar amount you are responsible for before your plan pays for healthcare services. Deductibles apply to the calendar year (January 1 - December 31), even if your coverage start date is after January 1.

Drug tiers: Drugs on a drug list/formulary are typically arranged in tiers. Your drug's cost depends on its tier.

In-network coverage: In-network coverage means visiting a participating doctor, hospital, or another provider who accepts a negotiated amount from your health insurance plan.

Network: A network is made up of doctors, hospitals, pharmacies, and other providers offering medical care at negotiated rates to health plan members.

Out-of-network coverage: Out-of-network coverage means visiting a doctor, hospital, or another provider who does not accept your health insurance plan. You will be responsible for covering care costs minus emergent or preapproved services.

Out-of-pocket maximum: This is the maximum amount you will pay out-of-pocket for covered health services. After reaching your yearly maximum, your health plan covers the rest.

Plan name: The plan name and contract code are found on the first row of the medical plan charts, in parentheses after the plan name: "(WXYZ)."

Premium: This is the amount of money you pay monthly to your insurance company to keep your health plan active. You cannot apply what you pay for your premium toward your deductible.

Preventive care: These are medical services, like checkups, screenings, and vaccines, that can help you avoid illness and catch problems early. Preventive care is covered at $0 when you visit a provider in your plan's network.

Important legal information

Before choosing a health benefit plan, please review the following information along with the other materials enclosed.

Eligibility for a minimum coverage plan only

You are eligible for this plan if you also:

- are under age 30 before the plan's effective date; or
- have received certification from Covered California that you are exempt from the individual mandate because you qualify for a hardship exemption or do not have an affordable coverage option

Open enrollment

An annual open enrollment period is provided for enrollees in compliance with state and federal requirements. Individuals may enroll in a Plan and members may change their Agreement at that time.

Effective dates for annual open enrollment period:

The earliest effective date is the first day of the following benefit year. The actual effective date is determined by the date Anthem receives a complete application with the applicable premium payment.

If payment is received between the 1st through 15th of the month, the effective date is the first of the next month. If payment is received between the 16th through end of the month, the effective date is the first of the month after the next month.

Special enrollment

In addition to open enrollment, an individual can enroll during the special enrollment period. This is a period of time in which eligible individuals or their dependents can enroll after the open enrollment, typically due to an event such as marriage, birth, adoption, or other qualifying events as defined by law.

Depending on the nature of the qualifying event, coverage may be effective as of the date of the qualifying event.

Effective dates for special enrollment periods:

- In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
- In the case of marriage, domestic partnership or in the case where an individual loses minimum essential coverage, coverage is effective on the first day of the following month after your application is received.
- For other qualifying events, when the application is received between the first day and the fifteenth day of the month, the effective date is the first day of the following month. When the application is received between the sixteenth day and last day of the month, the effective date is the first day of the second following month.
- In the case of new access to an ICHRA or new provision of a QSEHRA, if the plan selection is made before the day of the triggering event, coverage is effective on the first (1st) day of the month following the date of the triggering event or, if the triggering event is on the first (1st) day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, coverage is effective on the first (1st) day of the month following the plan selection.

You must elect coverage and notify us within sixty (60) days.

Effective dates for special enrollment due to loss of minimum essential coverage apply when the loss of minimum essential coverage includes loss of eligibility for coverage as a result of:

- Legal separation, dissolution of domestic partnership or divorce;
- Cessation of dependent status, such as attaining the maximum age;
- Death of an employee;
- Termination of employment;
- Reduction in the number of hours of employment; or
- Any loss of eligibility for coverage after a period that is measured by reference to any of the following:
  - Individual who no longer resides, lives or works in the Plan's service area,
  - A situation in which the Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,

Important legal information

- Termination of employer contributions, and
- Exhaustion of COBRA benefits.

There is no special enrollment for loss of minimum essential coverage when the loss includes termination or loss due to:

- Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
- Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Managing your care if you need to go to a hospital or get certain medical treatment

If you or a family member need certain types of medical care (for example: surgery, treatment in a doctor's office, physical therapy, etc.), you may want to know more about these programs and terms. They may help you better understand your benefits and how your health plan manages these types of care.

Utilization review

Utilization review (UR) is a program that is part of your health plan. It lets us make sure you are getting the right care at the right time. Our utilization review team, made up of licensed health care professionals such as nurses and doctors, does medical reviews. The team goes over the information your doctor has sent us to see if the requested surgery, treatment or other type of care is medically necessary. The utilization review team checks to make sure the treatment meets certain clinical guidelines set by us. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The utilization review team will let you and your doctor know as soon as possible. Decisions not to approve are put in writing. The written notice will include information on how to appeal the decision and about your rights to an independent medical review.

Reviewing where services are provided

A service must be medically necessary to be a covered service. The utilization review may include a review of the level of care, type of setting or place of service where services can be safely given to you. If services are given in a higher level of care or cost setting when they could be safely given in a lower level place of care or cost setting, they will not be determined to be medically necessary. The service(s), in that case, are being denied based on the review of where they are provided. When this happens the service(s) can be requested again in another setting or place of care and will be reviewed again for medical necessity. At times, a different type of provider or facility may need to be used in order for the service to be considered medically necessary.

Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a hospital but may be approved if provided on an outpatient basis in a hospital setting.
- A service may be denied on an outpatient basis if taking place in a hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical center/facility, or in a physician's office.
- A service may be denied at a skilled nursing facility but may be approved in a home setting.

We can do medical reviews like this before, during and after a member's treatment. Here is an explanation of each type of review:

The pre-service review (done before you get medical care)

We may do a pre-service review before a member goes to the hospital or has other types of services or treatment.

The continued stay review (done during medical care and recovery)

We do a continued stay review when you are in the hospital or are released and need more care related to the hospital stay. This could mean services or treatment, such as physical therapy or durable medical equipment. The utilization review team looks at the member's medical information at the time of the review to see if the treatment is medically necessary.

The post-service review (done after you get medical care)

We do a post-service review when you have already had surgery or another type of medical care. When the utilization review team learns about the treatment, they look at the medical information the doctor or provider had about you at the time the medical care was given. The team then can see if the treatment was medically necessary.

Case management

Case management is conducted by a licensed health care professional who works with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Important legal information

Precertification

Precertification is the process of getting approval from your health plan before you get services. This process lets you know if we will cover a service, supply, therapy or drug. We approve services that meet our standards for needed and appropriate treatment. The guidelines we use to approve treatment are based on standards of care in medical policies, clinical guidelines and the terms of your plan. As these may change, we review our precertification guidelines regularly. Precertification is a type of pre-service review.

Here is how requesting precertification can help you:

Saving time. Preauthorizing services is a process of verifying, in advance, whether a proposed treatment, service or supply is medically necessary and/or medically appropriate. The doctors in our network ask for prior authorization for our members.

Saving money. Paying only for medically necessary services helps everyone save. Choosing a doctor who is in our network can help you get the most for your health care dollar.

What can you do? Choose an in network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need prior authorization or call us to ask. The doctor's office will ask for prior authorization for you. Plus, costs are usually lower with an in network doctor. If you choose an out of network provider, be sure to call us to get prior authorization. Out of network providers may not do that for you. Once you are a member, if you have a question about prior authorization, you can call the Member Service number on the back of your ID card.

Exclusive provider organization

An exclusive provider organization (EPO) plan provides access to a network of hospitals and providers who contract with Anthem to facilitate services to our members and who provide services at pre-negotiated discounted rates. Benefits for in network providers are based on a maximum allowed amount.

In network providers have an agreement in effect with Anthem and have agreed to accept the maximum allowed amount as payment in full. Out of network providers do not have an agreement with Anthem. Your personal financial costs when using out of network providers may be considerably higher than when you use in network hospitals or in network providers. **For most services, there may be no benefit provided when using an out of network provider. EPO plans only include out of network benefits for emergency care, urgent care, and ambulance services, or when a service is preapproved. Please refer to the Summary of Benefits carefully to determine these differences.**

Health Maintenance Organization

A health maintenance organization (HMO) plan provides access to a network of hospitals and providers who contract with Anthem to facilitate services to our members and who provide services at pre-negotiated, discounted rates. Benefits for in network providers are based on that negotiated rate (negotiated fee rate).

In network providers have an agreement in effect with Anthem and have agreed to accept a set and agreed to dollar amount per member, per month. Out of network providers do not have an agreement with Anthem. Your personal financial costs when using out of network providers may be considerably higher than when you use in network hospitals or in network providers. **For most services, there may be no benefit provided when using an out of network provider. HMO plans only include out of network benefits for emergency care, urgent care, and ambulance services, or when a service is preapproved. Please refer to the Summary of Benefits carefully to determine these differences.**

Choosing a provider

You have the right to choose an in network provider or out of network provider as stated above. Choosing an out of network provider may impact your personal financial costs. Please refer to the Summary of Benefits to review copayment and coinsurance differences between these types of providers since your responsibility is often significantly higher when you use an out of network provider.

Some hospitals and other providers do not offer one or more of the following services that may be covered under your Agreement and that you or your family member might need:

- Family planning;
- Contraceptive services, including emergency contraception;
- Sterilization, including tubal ligation at the time of labor and delivery;
- Infertility treatments; or

Important legal information

- Abortion

You should obtain more information before you become a member or select an in network provider. Call your prospective doctor or clinic, or call Anthem at **855-383-7247** to ensure that you can obtain the health care services that you need.

In network providers include primary care doctors / providers (PCPs), specialists (specialty care physicians / providers (SCPs)), other professional providers, hospitals, and other facilities that contract with us to care for you. See your member Agreement for referral requirements.

Laws and rights that protect you

As a member, you have rights and responsibilities. You have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. You also have certain rights and responsibilities when receiving your health care. Visit this link to find more information on our website: **http://www.anthem.com/ca/health-insurance/customer-care/faq**.

Exclusions

The specific exclusions are spelled out in the terms of the particular plan, but some of the more common services not covered by these plans are:

- Care provided by a member of your family
- Care received in an emergency room that is not emergency care, except as specified in the Agreement
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Charges greater than the negotiated fee rate (HMO); charges greater than the maximum allowed amount (EPO)
- Comfort and/or convenience items
- Compound drugs except as described in the Agreement
- Consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications
- Cosmetic surgery
- Custodial care
- Fraud, waste, abuse, and other inappropriate billing. Services from a out of network provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes a out of network provider's failure to submit medical records required to determine the appropriateness of a claim
- Health club memberships and fitness services
- In-vitro fertilization (IVF) as described in the Agreement
- Nutritional and dietary supplements, except as mandated
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails)
- Services that are not medically necessary
- Vision, except as described in the Agreement
- Workers' compensation

Medical loss ratio

Law requires us to tell you that Anthem Blue Cross' medical loss ratio (MLR) for 2021 was 84.7%. This ratio was calculated after provider discounts were applied, and is based on state and federal regulatory rules and regulations, including the federal MLR regulations.

The following EPO and HMO plans are issued by Anthem Blue Cross – Anthem Bronze 60 D EPO; Anthem Bronze 60 D HDHP EPO; Anthem Bronze 60 D HMO; Anthem Gold 80 D EPO; Anthem Gold 80 D HMO; Anthem Minimum Coverage D EPO; Anthem Minimum Coverage D HMO; Anthem Platinum 90 D EPO; Anthem Platinum 90 D HMO; Anthem Silver 70 Off Exchange EPO and Anthem Silver 70 Off Exchange HMO.

Important legal information

A high-deductible health plan is not a health savings account (HSA). An HSA is a separate arrangement between an individual and a qualified financial institution. To take advantage of tax benefits, an HSA needs to be established. This brochure provides general information only and is not intended to be a substitute for the advice of a qualified tax professional.

It is important we treat you fairly

That is why we follow federal civil rights laws in our health programs and activities. We do not 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 is not 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.

California required Notice of Non-discrimination

Anthem does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats are available, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity for individuals with disabilities to effectively communicate with us.

Find help in your language

If you're curious to know what all this says, here is the English version:

If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (1-855-383-7247). (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 at **800-627-8797**.

Spanish

Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (1-855-383-7247). (TTY/TDD: 711)

Arabic

إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء.
(1-855-383-7247) (TTY/TDD: 711)

Armenian

Եթե այս փաստաթուղթն անհրաժեշտ լինի Ձեզ այլ լեզվով, կարող եք խնդրել այն Անդամների սպասարկման կենտրոնից՝ զանգահարելով (1-855-383-7247) հեռախոսահամարով: Այն Ձեզ անվճար կտրամադրվի: (TTY/TDD: 711)

Chinese

如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(1-855-383-7247)請求免費協助。(TTY/TDD: 711)

Farsi

در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید،
می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با
مرکز خدمات اعضاء به شماره 1-855-383-7247 تماس بگیرید، (TTY/TDD: 711)

Hindi

अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (1-855-383-7247) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Hmong

Yog hais tias koj xav tau kev pab txhawm rau kom nkag siab txog daim ntawv no hais ua lwm hom lus, tej zaum koj kuj yuav thov tau yam tsis xam tus nqi dab tsi ntxiv hlo li uas yog hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab (1-855-383-7247). (TTY/TDD: 711)

Japanese

この書面を他の言語で理解するための支援が必要な場合には、メンバーサービス番号（1-855-383-7247）に電話して支援を求めることができます。追加費用はかかりません。(TTY/TDD: 711)

Khmer

បីអ្នកតម្រូវការជំនួយក្នុងការយល់ពីឯកសារនេះជាភាសាផ្សេង អ្នកអាចស្នើវាដាយឥតគិតថ្លៃបែនថមែដាយហៅទូរស័ព្ទទៅលេខសេវាសមាជិក
(1-855-383-7247)។(TTY/TDD: 711)

Korean

다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(1-855-383-7247)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਕਿਸੇ ਬਦਲਵੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਤੁਸੀਂ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ (1-855-383-7247) ਤੇ ਕਾਲ ਕਰਕੇ ਕਿਸੇ ਵਾਧੂ ਲਾਗਤ ਦੇ ਬਿਨਾਂ ਇਸ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। (TTY/TDD: 711)

Find help in your language

Russian

Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (1-855-383-7247). (TTY/TDD: 711)

Tagalog

Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (1-855-383-7247). (TTY/TDD: 711)

Thai

หากท่านต้องการความช่วยเหลือเพื่อทำความเข้าใจเกี่ยวกับเอกสารนี้ในภาษาอื่น ท่านอาจขอรับบริการได้โดยไม่เสียค่าใช้จ่ายเพิ่มเติมใดๆ โดยโทรไปที่หมายเลขฝ่ายบริการสมาชิก (1-855-383-7247) (TTY/TDD: 711)

Vietnamese

Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (1-855-383-7247). (TTY/TDD: 711)

Open enrollment period runs

November 1, 2022 - January 31, 2023

Enroll between November 1 through December 31 for January 1, 2023 effective date and between January 1, 2023 through January 15, 2023 for a February 1, 2023 effective date.

Reimagining what's possible for every moment of care

We know finding a plan that works for you and your loved ones is a big decision. With Anthem you're never alone for the important choices.

Get started today

- Call us at **888-811-2101**, 5:30 a.m. to 5:00 p.m. PT or contact your Authorized Agent.
- Visit **anthem.com/ca**, select **Individual and Family**, and apply online.
- For off-Marketplace plans, review the **application** included with this brochure.

Let us connect you to the right individual coverage.

Qualifying life events

If you experience a major life event, you may need to make plan changes outside the sign-up period. To see if your life event qualifies for a plan change, call us at **888-811-2101** or contact your Authorized Agent.

You can buy health plans once a year during open enrollment. Healthcare plans can also be purchased as a result of a special enrollment period. For 2023, the open enrollment period runs from **November 1, 2022 - January 31, 2023.** Be sure to enroll by December 31, 2022, to start coverage effective January 1, 2023. **Dates may change and vary by state.**

When you enroll in one of our plans, you will have access to your *Agreement*, which explains the terms and conditions of coverage, including exclusions and limitations. You will have 10 days to examine your Agreement's features. If you are not fully satisfied during that time, you may cancel your coverage and your monthly payment will be refunded, minus any claims that were already paid.

Printed kits available from your Authorized Agent upon request.

A02055CAMENABC 7/22