California

2021 Plan Year Benefit Charts

Individual and Family
Bronze, Silver, Gold, Platinum and Minimum Coverage plans
EPO and HMO plans Offered by Anthem Blue Cross

Open Enrollment Period runs
November 1, 2020 - January 31, 2021

HEALTH COVERAGE CREATED WITH YOU IN MIND

Experience the Anthem difference

06314CAMENABC 7/20

benefits for emergency care, urgent care and ambulance services. The benefit information

Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tulare, T

Anthem Bronze 60 D EPO (5JNF)	Anthem Bronze Pathway EPO 6800 (5JND)	Anthem Bronze Pathway EPO 6900 (5JN9)	Anthem Bronze 60 D HDHP EPO (5JNH)	Anthem Bronze Pathway EPO 7100 (5JNC)	Anthem Silver 70 Off Exchange EP (5JNA)
Pathway – EPO	Pathway – EPO	Pathway – EPO	Pathway – EPO	Pathway – EPO	Pathway – EPO
No	No	No	No	No	No
$6,300	$6,800	$6,900	$7,000	$7,100	$4,000
$8,200	$8,550	$8,550	$7,000	$8,550	$8,200
40%	25%	20%	0%	20%	20%
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.
$65 copay per visit for the first 3 visits, then deductible and $65 copay	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	$40 copay, deductible waived
$95 copay per visit for the first 3 visits, then deductible and $95 copay	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	$80 copay, deductible waived
0% coinsurance, deductible waived	0% coinsurance, deductible waived	0% coinsurance, deductible waived	Deductible, then 0% coinsurance	0% coinsurance, deductible waived	0% coinsurance, deductible waive
Deductible, then 40% coinsurance	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	$85 copay, deductible waived
Deductible, then 40% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 0% coinsurance	Deductible, then 50% coinsurance	$325 copay, deductible waived
$65 copay per visit for the first 3 visits, then deductible and $65 copay	Deductible, then $50 copay and 25% coinsurance	Deductible, then $50 copay and 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then $50 copay and 20% coinsurance	$40 copay, deductible waived
Deductible, then 40% coinsurance	Deductible, then $200 copay and 25% coinsurance	Deductible, then $350 copay and 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then $200 copay and 20% coinsurance	$400 copay, deductible waived
Deductible, then 40% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Deductible, then 40% coinsurance	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	20% coinsurance, deductible waiv
Tiers 1, 2, 3, 4: $500 Combined pharmacy deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1: No deductible Tiers 2, 3, 4: Medical deductible applies	Tiers 1, 2, 3, 4: $300 Combined pharmacy deductible
$18 copay	25% coinsurance (up to $500 per script) / 35% coinsurance (up to $500 per script)	20% coinsurance (up to $500 per script) / 30% coinsurance (up to $500 per script)	0% coinsurance	$30 copay / $40 copay	$16 copay
40% coinsurance (up to $500 per script)	25% coinsurance (up to $500 per script) / 35% coinsurance (up to $500 per script)	20% coinsurance (up to $500 per script) / 30% coinsurance (up to $500 per script)	0% coinsurance	20% coinsurance (up to $500 per script) / 30% coinsurance (up to $500 per script)	$60 copay
40% coinsurance (up to $500 per script)	40% coinsurance (up to $500 per script) / 50% coinsurance (up to $500 per script)	40% coinsurance (up to $500 per script) / 50% coinsurance (up to $500 per script)	0% coinsurance	40% coinsurance (up to $500 per script) / 50% coinsurance (up to $500 per script)	$90 copay
40% coinsurance (up to $500 per script)	40% coinsurance (up to $500 per script) / 50% coinsurance (up to $500 per script)	40% coinsurance (up to $500 per script) / 50% coinsurance (up to $500 per script)	0% coinsurance	40% coinsurance (up to $500 per script) / 50% coinsurance (up to $500 per script)	20% coinsurance (up to $250 per script)
$65 copay, deductible waived	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	$40 copay, deductible waived

benefits for emergency care, urgent care and ambulance services. The benefit information

Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tu

Anthem Platinum 90 D EPO (5JNM)	Anthem Minimum Coverage D EPO (5JNK)
Pathway – EPO	Pathway – EPO
No	No
$0	$8,550
$4,500	$8,550
10%	0%
No additional cost to you.	No additional cost to you.
$15 copay	0% coinsurance per visit for the first 3 visits, then deductible and 0% coinsurance
$30 copay	Deductible, then 0% coinsurance
0% coinsurance	0% coinsurance per visit for the first 3 visits, then deductible and 0% coinsurance
$30 copay	Deductible, then 0% coinsurance
10% coinsurance	Deductible, then 0% coinsurance
$15 copay	0% coinsurance per visit for the first 3 visits, then deductible and 0% coinsurance
$150 copay	Deductible, then 0% coinsurance
10% coinsurance	Deductible, then 0% coinsurance
10% coinsurance	Deductible, then 0% coinsurance
Tiers 1, 2, 3, 4: No deductible	Tiers 1, 2, 3, 4: Medical deductible applies
$5 copay	0% coinsurance
$15 copay	0% coinsurance
$25 copay	0% coinsurance
10% coinsurance (up to $250 per script)	0% coinsurance
$15 copay	Deductible, then 0% coinsurance
$15 copay	Deductible, then 0% coinsurance

k benefits for emergency care, urgent care and ambulance services. The benefit information

Anthem Bronze 60 D HMO (5JNN)	Anthem Silver Pathway HMO (5KDL)	Anthem Silver 70 Off Exchange HMO (5JNB)	Anthem Gold 80 D HMO (5JNE)	Anthem Platinum 90 D HMO (5JNJ)	Anthem Minimum Coverage D HM (5JNL)
Pathway - HMO	Pathway - HMO	Pathway - HMO	Pathway - HMO	Pathway - HMO	Pathway - HMO
No	No	No	No	No	No
$6,300	$0	$4,000	$0	$0	$8,550
$8,200	$8,550	$8,200	$8,200	$4,500	$8,550
40%	0%	20%	20%	10%	0%
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.
$65 copay per visit for the first 3 visits, then deductible and $65 copay	$50 copay	$40 copay, deductible waived	$35 copay	$15 copay	0% coinsurance per visit for the fir visits, then deductible and 0% coinsurance
$95 copay per visit for the first 3 visits, then deductible and $95 copay	$85 copay	$80 copay, deductible waived	$65 copay	$30 copay	Deductible, then 0% coinsurance
0% coinsurance, deductible waived	0% coinsurance	0% coinsurance, deductible waived	0% coinsurance	0% coinsurance	0% coinsurance per visit for the fir visits, then deductible and 0% coinsurance
Deductible, then 40% coinsurance	$85 copay	$85 copay, deductible waived	$75 copay	$30 copay	Deductible, then 0% coinsurance
Deductible, then 40% coinsurance	$450 copay	$325 copay, deductible waived	$150 copay	$75 copay	Deductible, then 0% coinsurance
$65 copay per visit for the first 3 visits, then deductible and $65 copay	$50 copay	$40 copay, deductible waived	$35 copay	$15 copay	0% coinsurance per visit for the fir visits, then deductible and 0% coinsurance
Deductible, then 40% coinsurance	$750 copay	$400 copay, deductible waived	$350 copay	$150 copay	Deductible, then 0% coinsurance
Deductible, then 40% coinsurance	$1,500 copay per day up to 5 days per admission	Deductible, then 20% coinsurance	$600 copay per day up to 5 days per admission	$250 copay per day up to 5 days per admission	Deductible, then 0% coinsurance
Deductible, then 40% coinsurance	$750 copay	20% coinsurance, deductible waived	$300 copay	$100 copay	Deductible, then 0% coinsurance
Tiers 1, 2, 3, 4: $500 Combined pharmacy deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: $400 Combined pharmacy deductible	Tiers 1, 2, 3, 4: $300 Combined pharmacy deductible	Tiers 1, 2, 3, 4: No deductible	Tiers 1, 2, 3, 4: No deductible	Tiers 1, 2, 3, 4: Medical deductible applies
$18 copay	$18 copay / $28 copay	$16 copay	$15 copay	$5 copay	0% coinsurance
40% coinsurance (up to $500 per script)	$70 copay / $80 copay	$60 copay	$55 copay	$15 copay	0% coinsurance
40% coinsurance (up to $500 per script)	$95 copay / $105 copay	$90 copay	$80 copay	$25 copay	0% coinsurance
40% coinsurance (up to $500 per script)	20% coinsurance (up to $250 per script) / 30% coinsurance (up to $250 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
$65 copay, deductible waived	$50 copay	$40 copay, deductible waived	$35 copay	$15 copay	Deductible, then 0% coinsurance
$65 copay, deductible waived	$50 copay	$40 copay, deductible waived	$35 copay	$15 copay	Deductible, then 0% coinsurance

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, mammograms and more, 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 For plans with **PCP, Specialist** and **Urgent Care** office visit limits, the visit limits are combined, not separate.

4 For plans with a **Pharmacy deductible**, the pharmacy deductible is separate from the medical deductible. The family deductible is 2 times the individual amount.

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.

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,
  - 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. **You will be responsible for any amount not paid by Anthem when using the services of an out of network provider. 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 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. You will be responsible for any amount not paid by Anthem when using the services of an out of network provider. **For most services, there may be no benefit provided when using an out of network provider. 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
- Abortion

IMPORTANT LEGAL INFORMATION

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. Referrals are never needed to visit an in network specialist including behavioral health providers.

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:

- Benefits covered by Medicare or a governmental program, unless otherwise required by law or regulation
- 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
- 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
- Health club memberships and fitness services
- In-vitro fertilization (IVF) as described in the Agreement's exclusions
- Nutritional and dietary supplements, except as mandated
- 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 2019 was 85.9%. 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 Pathway EPO 6800; Anthem Bronze Pathway EPO 6900; Anthem Bronze Pathway EPO 7100; Anthem Silver 70 Off Exchange EPO; Anthem Gold 80 D EPO; Anthem Platinum 90 D EPO; Anthem Minimum Coverage D EPO; Anthem Bronze 60 D HMO; Anthem Silver 70 Off Exchange HMO; Anthem Silver Pathway HMO; Anthem Gold 80 D HMO; Anthem Platinum 90 D HMO and Anthem Minimum Coverage D HMO.

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.

IMPORTANT LEGAL INFORMATION

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, exclude people, or treat them differently on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender identity, sexual orientation, age or disability. For people with disabilities, we offer free aids and services, and information in alternate formats, free of charge and in a timely manner, when necessary to ensure an equal opportunity to participate.

GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be too. 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 1-800-627-8797.

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

បើអ្នកត្រូវការជំនួយក្នុងការយល់ពីឯកសារនេះជាភាសាផ្សេង អ្នកអាចស្នើវាដោយឥតគិតថ្លៃបន្ថែមដោយហៅទូរស័ព្ទទៅលេខសេវាសមាជិក (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 ਤੁਸੀ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ (1-855-383-7247) ਤੇ ਕਾਲ ਕਰਕੇ ਕਿਸੇ ਵਾਧੂ ਲਾਗਤ ਦੇ ਬਿਨਾਂ ਇਸ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। (TTY/TDD: 711)

GET 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)

EXPERIENCE THE ANTHEM DIFFERENCE

Start by:

- Calling your Authorized Agent or call us at **1-888-811-2101**, 8:30 am to 8:00 pm EST
- Taking a look at the application included with this brochure
- Visiting **anthem.com/ca**, select **Individual and Family**, and applying online

You can buy health care plans once a year during open enrollment. For 2021, this period runs from **November 1, 2020 - January 31, 2021.** Dates may change and vary by state. Be sure to enroll by December 15, 2020, to start coverage effective January 1, 2021.

We know that sometimes big life events happen and you may need to make plan changes outside the open enrollment period. To see if your life event qualifies for a plan change, contact your Authorized Agent or call us at the number above.

When you enroll in one of our plans, you will have access to your Agreement that explains the terms and conditions of coverage, including exclusions and limitations. You will have 30 days to examine your Agreement's features. If you are not fully satisfied during that time, you may cancel your coverage and your premium will be refunded, minus any claims that were already paid.

HERE EVERY STEP OF THE WAY.

Let us help you find a plan that meets your needs. Contact your Authorized Agent or call us at **1-888-811-2101**, 8:30 am to 8:00 pm EST. You can also visit **anthem.com/ca** and select Individual and Family.

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EMBEDDED PEDIATRIC DENTAL BENEFITS DETAILS

Embedded pediatric dental benefits are included with all of our medical plans for members until the end of the month in which they turn 19. Coverage includes preventive care, fillings and some other major services like medically necessary orthodontia.

- Shared deductible for medical and dental services
- Shared out-of-pocket maximum for medical and dental services

	Non-standard medical plans[1]	Standard medical plans[2]	Minimum coverage medical plans
	in network / out of network[3]	*in network / out of network*[3]	*in network / out of network*[3]
Dental network	Dental Prime	Dental Prime	Dental Prime
Deductible[4]	All dental services subject to the medical deductible	No deductible	Dental services subject to the medical deductible except diagnostic and preventative services[5]
Annual maximum (per person)	None	None	None
Annual out-of-pocket maximum	Combined with medical	Combined with medical	Combined with medical
Diagnostic and preventive	*No waiting period*	*No waiting period*	*No waiting period*
Cleaning, exams, x-rays	0% / 0% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
Basic services	*No waiting period*	*No waiting period*	*No waiting period*
Fillings	50% / 50% coinsurance	20% / 20% coinsurance	0% / 20% coinsurance
Complex and major services	*No waiting period*	*No waiting period*	*No waiting period*
Endodontic/periodontic/oral surgery	50% / 50% coinsurance	50% / 50% coinsurance	0% / 50% coinsurance
Major services	50% / 50% coinsurance	50% / 50% coinsurance	0% / 50% coinsurance
Medically necessary orthodontia[6]	50% / 50% coinsurance	50% / 50% coinsurance	0% / 50% coinsurance
Cosmetic orthodontia	Not covered	Not covered	Not covered

1 Non-standard plans are based on the Standard Benefit Plan Designs, but differ in some ways to provide more options for cost sharing and deductibles. These are offered only off the Marketplace (Covered California).

2 Standard plans follow the Standard Benefit Plan Designs from Covered California. These are offered both on and off Covered California.

3 The out of network pediatric dental benefits displayed only apply if the medical plan provides for out of network coverage.

4 For medical plans where the deductible equals the out-of-pocket maximum, any services subject to the deductible have coinsurance of 0% after deductible.

5 Non-Standard Minimum Coverage (Catastrophic) plans have all dental services subject to the medical deductible.

6 Orthodontia is usually considered dentally necessary when a child's teeth are misaligned (crooked or not spaced correctly) to the point where they don't work properly. This could cause the child to have trouble speaking or eating. Some examples would be (1) if a child can't bite into an apple because they can't close their front teeth together or (2) if a child bites into the gum tissue of the palate (roof of the mouth) when they try to bite down.

EMBEDDED PEDIATRIC VISION BENEFITS DETAILS

The following vision care services are covered for members until the end of the month in which they turn 19. Coverage may include eye exams, eye glass lenses, frames and contact lenses. The benefit period is the calendar year (January 1 through December 31).

- If you purchase a Catastrophic plan, you must meet your medical deductible before pediatric vision benefits are paid.
- providers may bill you for any charges that exceed the plan's maximum allowed amount.
- pediatric vision benefits displayed only apply if the medical plan provides for out of network coverage.

	Benefit frequency	Cost share *in network / out of network*
Eye exam	Once every benefit period	\$0 copay / \$0 copay up to maximum allowed amount
Lenses (single, biofocal, trifocal and standard progressive)	Once every benefit period	\$0 copay / \$0 copay up to maximum allowed amount
Frames	Once every benefit period	Anthem formulary[1] / \$0 copay up to maximum allowed amount
Contact lenses (Non-elective)	Once every benefit period[2]	Covered in full / \$0 copay up to maximum allowed amount
Contact lenses (Elective/disposable)	Once every benefit period[2]	Anthem formulary[1] / \$0 copay up to maximum allowed amount
Low vision services (reading and computer glasses)	Once every benefit period	\$0 copay / Not covered (benefits are only available when received from Blue View Vision providers)

1 A collection of frames and lenses that can be purchased for a \$0 copay (may differ by provider).
2 Benefits for contact lenses are in lieu of the eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.

COUNTY NETWORK COVERAGE MAP

Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Mendocino
Glenn
Butte
Sierra
Lake
Colusa
Sutter
Yuba
Nevada
Placer
Sonoma
Napa
Yolo
Sacra-
mento
El Dorado
Alpine
Amador
Solano
Marin
Calaveras
Tuolumne
Contra Costa
San Joaquin
Mono
San Francisco
Alameda
Stanislaus
Mariposa
San Mateo
Santa Clara
Merced
Santa Cruz
Madera
Fresno
San Benito
Inyo
Tulare
Monterey
Kings
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Orange
Riverside
San Diego
Imperial

CALIFORNIA

Anthem Blue Cross Individual Health Care Coverage Service Area Effective 1/1/2021

Not all networks are available in all counties. Check this map to see what is available in your area.*

= Pathway – EPO

= Pathway – HMO

* While we make efforts to ensure that our lists of doctors, hospitals, and other providers are up to date and accurate, providers do leave our networks from time to time, and the listings included on *Find a Doctor/Find Care* at **anthem.com/ca** do change.

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FOUR WAYS YOUR HSA CAN WORK FOR YOU

Keeping track of different health care plans and cards to manage expenses can be confusing. Your Health Savings Account or HSA can help you pay for health care expenses, including prescriptions. It can also help you manage your care – all with a single debit card, website, mobile app and phone number. Plus, you can claim your HSA contributions as tax deductions, earn interest on your money and roll over the year-end balance.

You receive one debit card to make paying for out-of-pocket expenses simple.

You can find all your benefit and spending account information on one website.

- Check your HSA balance.
- Look for doctors, other health care professionals, hospitals and facilities.
- Review your claims, find out if you owe anything for care and pay your balance directly from your HSA online.
- See your benefit information, including deductible and out-of-pocket responsibilities.
- Estimate the cost of care before you see a doctor.

Whether you are home or traveling, the Sydney Health mobile app allows you to:

- See all of your account and claims information.
- Take a photo of a receipt and upload it for reimbursement.
- Manage and send payments from your HSA.
- Find care wherever you are, 24/7.

You can download the app from the App Store® or Google Play™.

You have one phone number for all your customer service needs.

RECEIVE REAL-TIME ALERTS FOR YOUR HSA

Do you want to know if your balance is low, receive confirmation of your deposit or see if an account statement is available? Sign up for email or text message alerts at anthem.com/ca to stay on top of HSA updates.

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USING YOUR HSA

Open your HSA

In order to open an HSA, you must have an HSA-compatible, high-deductible health plan.

Once you decide to open your HSA, our banking partner will confirm your identity, as required by law, and notify you if additional information is needed.[1]

Keep in mind, the information you provide at enrollment is used to open your account and confirm your identity. It is important that you enroll using your legal name to avoid delays in opening your account.

Receive your welcome letter and debit card

Once your account is open:

- You can log on to **anthem.com/ca** to see your account information at any time.
- You can learn more about your health plan, benefits and HSA at **anthem.com/ca**.
- You will receive a welcome letter and debit card issued to you and your spouse or domestic partner.[2]

1 Under the Patriot Act, all financial institutions are required to confirm the identity of anyone opening a new account through the Consumer Identification Program (CIP).

2 A debit card will automatically be issued to you and your spouse or domestic partner. If you need debit cards for other dependents, you can order them online at anthem.com/ca or call Member Services at the number on your ID card.

Transfer HSA funds

If you already have an HSA, you can transfer your funds to your new HSA.

- **One account experience.** With your funds in one place, you will have one login, one statement, one mobile app, one support team and one debit card.
- **No unnecessary fees.** By consolidating funds and closing your other account, you eliminate account administration fees from your prior HSA custodian.
- **Easier tax filings.** By having one HSA for the whole year, you will only have one set of tax forms to manage when it comes time to file your taxes.
- **Increased investment opportunity.** By combining your accounts, you have the maximum opportunity to grow your savings for the future.

We are here to help if you need it. After your account is open, visit **anthem.com/ca** or the Sydney Health app. You can also call Member Services at the number on the back of your ID card for more information. Please note that your prior HSA custodian may charge a fee to transfer and close your account.

This is what the IRS requires if you want to open an HSA:

- You must be covered by an HSA-compatible, high-deductible health plan.
- You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa.
- You cannot be covered by any other comprehensive medical plan that is not an HSA-compatible, high-deductible health plan.
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent on another individual's tax return.
- If you are a veteran, you may not have received veteran's benefits within the last three months, unless those benefits are related to a service-connected disability.
- You cannot be enrolled in TRICARE, the federal government insurance program for active and retired military.
- Your spouse cannot be enrolled in a flexible spending account (FSA) plan.

Note: You have the option of using a different financial institution to set up your HSA. However, you would be responsible for any HSA-related fees applied by the chosen financial institution.

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