Anthem

California Individual & Family Plan Summary

Prepared on October 1st, 2020

	Anthem Silver Pathway HMO (5KDL)**
Network Name	Pathway - HMO
Plan includes out-of-network coverage?	No
Plan Benefits	**In-network**
Individual Deductible	$0
Family Deductible	$0
Individual Out of pocket Maximum	$8,550
Family Out of pocket Maximum	$17,100
Coinsurance (Percentage may vary for some covered services)	0%
Preventive Care[1]	No additional cost to you.
Office Visit: Primary Care Physician (PCP)[2,3] (Other office services may be subject to deductible and plan coinsurance)	$50 copay
Office and Online Visit: Specialist[3] (Other office services may be subject to deductible and plan coinsurance)	$85 copay
Online Primary Care Doctor Visit: Livehealth Online	0% coinsurance
Outpatient Diagnostic Tests (Ex. X-ray, EKG)	$85 copay
Outpatient Advanced Diagnostic Tests (Ex. MRI, CT scan)	$450 copay
Laboratory	$50 copay
Urgent Care[3] (Other offices services may be subject to deductible and plan coinsurance)	$50 copay
Emergency Room Care (Copay, if applicable, waived if admitted into the hospital from the emergency room)	$750 copay

	Anthem Silver Pathway HMO (5KDL)**
Hospital: Inpatient Admission (Includes maternity, mental health / substance use)	$1,500 copay per day up to 5 days per admission
Hospital: Outpatient Surgery Hospital Facility (Includes maternity, mental health / substance use)	$750 copay
Pharmacy Deductible[4] (For tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: $400 Combined pharmacy deductible
Retail Pharmacy Tier 1	$18 copay / $28 copay
Retail Pharmacy Tier 2	$70 copay / $80 copay
Retail Pharmacy Tier 3	$95 copay / $105 copay
Retail Pharmacy Tier 4	20% coinsurance (up to $250 per script) / 30% coinsurance (up to $250 per script)
Dental and Vision	Pediatric dental and vision covered Adult dental and vision not covered
Chiropractic: Office Visits (Limits Apply)	Not covered
Physical and Occupational Therapy	$50 copay
Speech Therapy	$50 copay

EPO and HMO plans don't offer out-of-network benefits, except for emergency and urgent care, ambulance services or when a service is preapproved.

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

[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.

This plan grid offers a summary of the plans. Please refer to the Benefit Summaries for further details.

All product offerings are subject to regulatory review and approval.

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 for plans offered on Covered California

As established by the rules of Covered California, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP) or to change QHPs during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by Covered California.

American Indians are authorized to move from one QHP to another QHP once per month.

Effective date of coverage

The earliest effective date for the annual open enrollment period is the first day of the following benefit period for a Qualified Individual who has made a QHP selection during the annual open enrollment period. An applicant's effective date is determined by Covered California based on the receipt of the completed enrollment form.

Open enrollment for plans offered off the Marketplace

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 for plans offered on Covered California

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.

Special enrollment for plans offered off the Marketplace

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.

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

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/customercare/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
- 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 EPO; Anthem Bronze 60 HDHP EPO; Anthem Silver 70 EPO; Anthem Silver 73 EPO; Anthem Silver 87 EPO; Anthem Silver 94 EPO; Anthem Gold 80 EPO; Anthem Platinum 90 EPO; Anthem Minimum Coverage EPO; Anthem Bronze 60 HMO; Anthem Silver 70 HMO; Anthem Silver 73 HMO; Anthem Silver 87 HMO; Anthem Silver 94 HMO; Anthem Gold 80 HMO; Anthem Platinum 90 HMO and Anthem Minimum Coverage HMO on Covered California and 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 off the Marketplace.

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, 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.