

Connecting you to the right coverage

Dental and vision

2023 Individual and Family Plans



Plans off the Marketplace

Anthem Essential Choice PPO,
Anthem Dental Net 3000D plans and
Blue View Vision plans

For plans effective January 1, 2023 



Helping you feel covered, protected, and confident

Our plans for individuals and families are designed to help protect both your health and your finances. With a range of options suited to different budgets, we can connect you to the coverage that's right for you.

Why connected care matters

Regular dental checkups are about more than keeping your mouth healthy. They can help dentists identify health conditions like heart disease and diabetes.¹

Likewise, eye exams can help eye doctors find early signs of diabetes, high blood pressure, high cholesterol, and other serious health issues beyond your vision.²

That's why we want to make it easier for you to access the dental and vision care you need. ▶

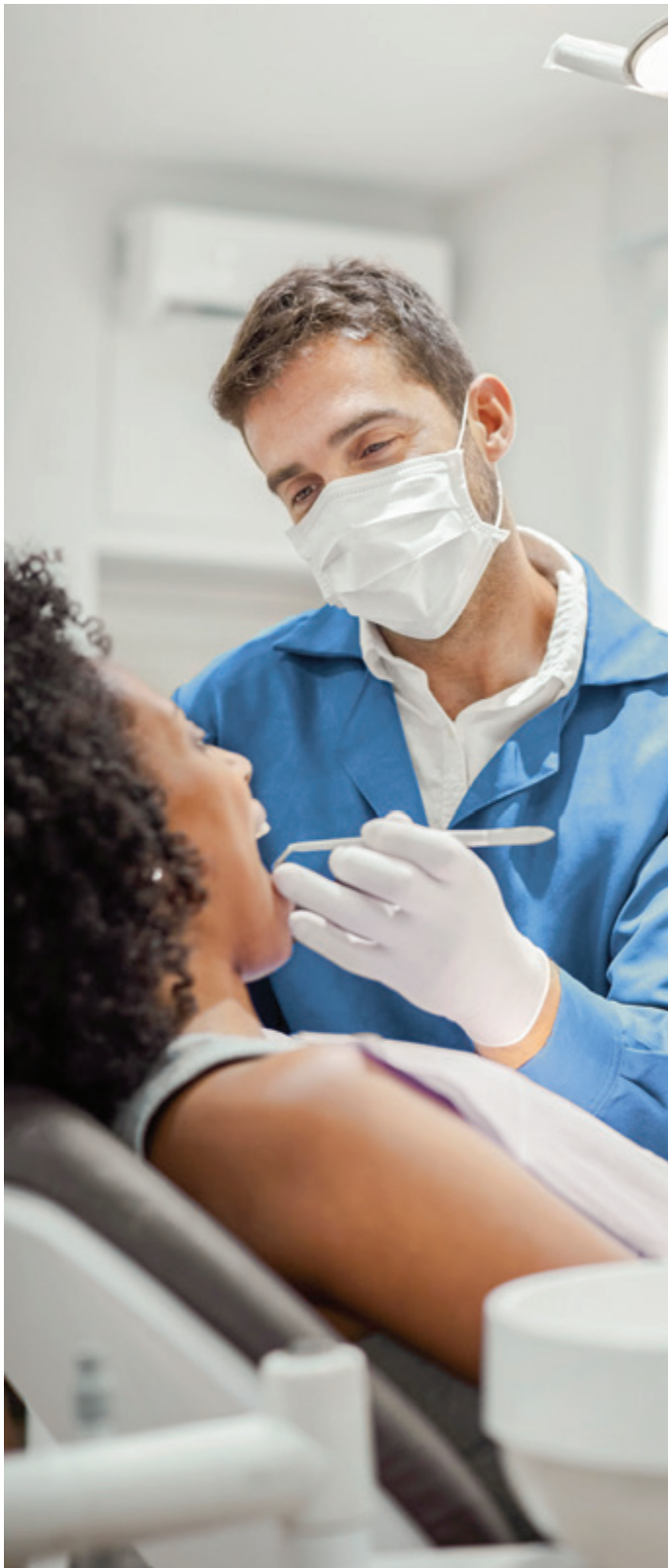
Purchasing a plan

To help protect your overall health, you can buy dental and vision plans on their own all year round without having to wait until the next open enrollment period.

¹ Centers for Disease Control and Prevention: *Oral Health Conditions* (accessed April 2022); [cdc.gov/oralhealth/conditions/index.html](https://www.cdc.gov/oralhealth/conditions/index.html).

² Your Sight Matters: 7 Health Problems Eye Exams Can Detect (accessed April 2022); yoursightmatters.com.

Dental plan benefits



When you choose Anthem, you can use one of the largest dental networks in the country. That means you're likely to find a dentist close to your home or work, or even be able to see a dentist you already know and trust.

Plus, you'll receive 100% coverage for preventive care, like regular dental cleanings, exams, and X-rays, when you go to a dentist in your plan. There are no waiting periods with preventive care, so those benefits can be used right away. Anthem has strong network discounts — our members save more by visiting one of our network dentists with our 38% average national network discount.*

Our Essential Choice PPO dental plans have higher annual benefit maximums. These plans allow you to carry over part of your unused benefits to the next year, with the potential to double your annual maximum benefit amount over time. Essential Choice PPO dental plans also feature shorter waiting periods than traditional plans for basic and major services, and our Incentive plan does not have any waiting periods.

Important health plan terms to know

Monthly premiums: your payments for plan benefits

Levels of coverage: the types of benefits covered

Deductibles: the amount of expenses you have to pay out of pocket every calendar year before your plan begins to pay for benefits

Benefit waiting period: the period of time you have to wait until your plan starts covering benefits

Copays: a fee you pay for each provider visit

Coinsurance: the amount you pay for healthcare services; usually a certain percentage of the cost after your deductible has been paid

* Anthem Network Discount report, 2022.

Dental plan benefits

We offer a variety of individual and family plan options, including:

Anthem Essential Choice PPO dental plans

You can choose among these five plan options, which offer different monthly premiums, annual benefit maximums, and levels of coverage.*

- **Bronze** — covers preventive care and basic services, including nonsurgical gum treatments and tooth removal
- **Silver** — covers major services, like root canals, oral surgery, crowns, bridges, and dentures; also covers cosmetic teeth whitening
- **Gold** — covers all of the above, with lower out-of-pocket costs for basic services; has a higher annual maximum benefit (\$1,500) than the Bronze and Silver plans
- **Platinum** — covers all of the above, plus dental implants and orthodontics for children; has a higher annual maximum benefit (\$2,000) than the Bronze, Silver, and Gold plans
- **Incentive** — innovative plan with no waiting periods for any services; offers rewards for receiving preventive care by increasing the benefits for basic and major services the next year; at \$2,500, has the highest annual maximum benefit of any plan

Anthem Dental Net 3000D plan

With the Anthem Dental Net 3000D plan, you can have dental coverage with no annual maximums, deductibles, or benefit waiting periods. The plan also has set copays for nearly 500 specific procedures, so you know what to expect when it comes to your out-of-pocket costs.

Plan features include:

- Approximately 500 covered dental procedures
- No annual maximum benefit
- No deductible
- No waiting periods
- Easy-to-understand copays
- Enhanced preventive care
- No claim forms
- Choice of general dentist and specialists



To compare dental plan benefits, [see our detailed charts](#).

* All five plans cover tooth-colored fillings on back teeth.

Dental plan resources



Lower your out-of-pocket costs

You will save the most money if you see a dentist in your plan's network. Those dentists have agreed to accept rates negotiated by your plan, so you can save money on the services you need, when you need them — including during any waiting periods and after you reach your annual maximum benefit.

Find a dentist

To find dental care near you, go to anthem.com/ca/find-care.

Helping you stay connected

Through technology and innovation, we are working hard to improve health outcomes, control costs, and enhance your overall care experience.

All our plans come with online tools to make it easier for you to find care, get your benefit information, and learn about different health topics. Once you become a member, you can simply log in to anthem.com/ca to use:

Ask a Hygienist

Email questions to licensed dental professionals and receive quick, private, and personalized advice at no extra cost.

Dental Cost Estimator

Estimate your costs for dental procedures and services in your ZIP code before receiving care.

Dental Health Assessment

Answer a few questions to get feedback about your dental health status.

TeleDentists[®]

Get virtual dental care, including emergency exams and medication prescriptions, as needed.

Dental care when you're away from home

If you travel outside the U.S., you have access to emergency dental services through the International Emergency Dental Program, which comes with all our plans.*

With one call, you can get help finding an English-speaking dentist when you have an urgent dental care need. You can even request translation services when you call the dentist's office. Services received through this program will not count toward your yearly limit, if your plan has one.

* The International Emergency Dental Program is managed by DeCare Dental. DeCare Dental is an independent company offering dental management services to Anthem Blue Cross.

Connected care and discounts

The Sydney Health app

Our app brings valuable health plan information together in one place — to put you in control and make staying on top of your care more convenient.

With SydneySM Health, you can:

- View digital ID cards and plan, prescription, or claims information.
- Use interactive chat for health questions.
- Find nearby care.
- Compare costs for healthcare services.
- Take advantage of the Symptom Assessment tool.

Once you enroll in one of our plans, Sydney Health is available for free download on the App Store[®] or Google Play[™].

You will need a smartphone, tablet, or other personal device to get started.

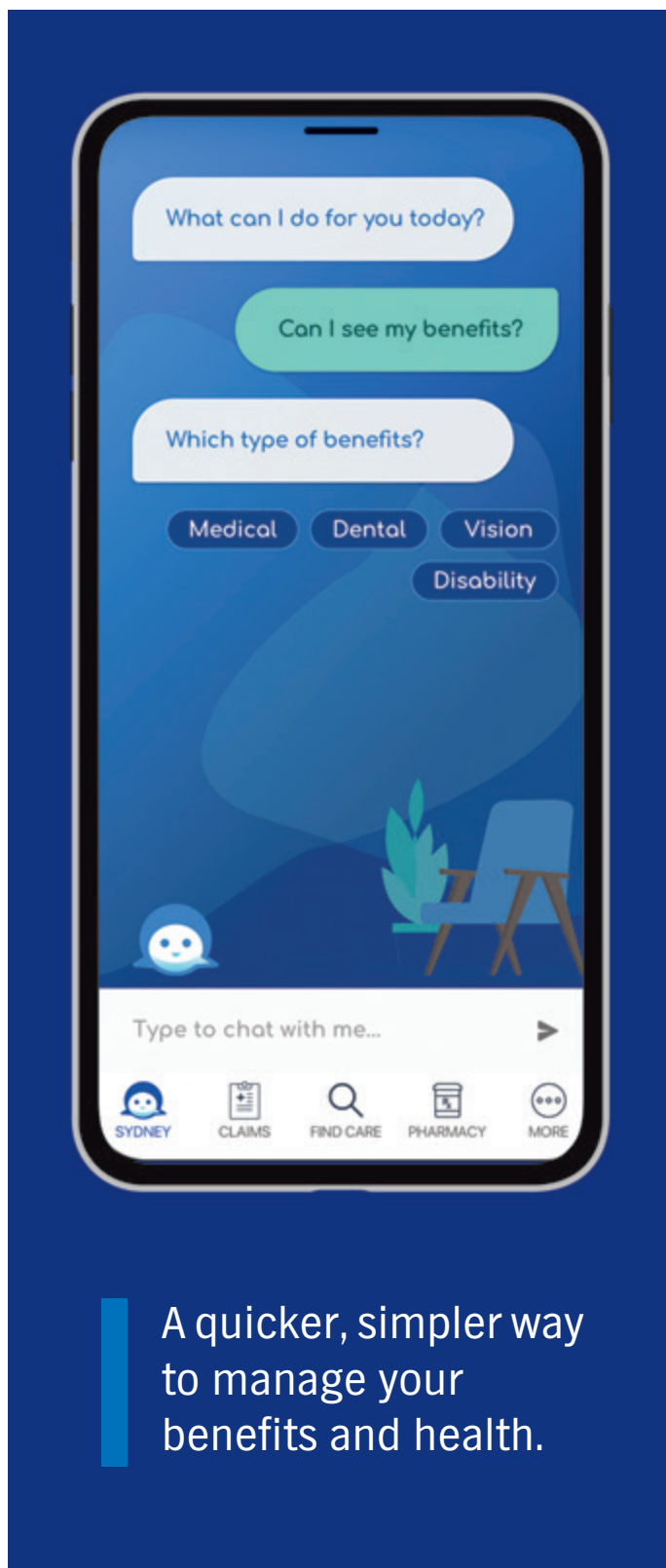
Discounts that make a difference

Through SpecialOffers@AnthemSM, you can also receive discounts on at-home teeth-straightening aligners and other health and wellness products and services that may not be covered under your plan.

A focus on whole-person health

The Anthem Whole Health Connection[®] program links your Anthem plans together — to give your doctors a more complete picture of your health.*

This makes managing all aspects of your care simpler, smarter, and more cost-effective. It also allows for truly meaningful connections, improved outcomes, and stronger relationships between you and your care team.



A quicker, simpler way
to manage your
benefits and health.

* Anthem Whole Health Connection is included at no extra charge for employees with Anthem health and wellness coverage and one or more of the following plans from us: pharmacy, dental, vision, disability, and supplemental health.

Blue View Vision plan benefits

With Blue View Vision, choose from more than 40,000 eye doctors and other eye care providers at over 30,000 locations.¹ You can go to an independent eye doctor or popular retailers, such as LensCrafters[®] and Target Optical[®]. Our network is one of the largest in the country, so you'll be able to receive your eye care, glasses, and other accessories just about anywhere. Plus, you'll have 24/7 access to online stores, including 1-800 CONTACTS[®].

Plan features

Our plans are designed to give you options. They all have:

- Coverage for yearly eye exams.
- Add-ons, including factory scratch coating on eyeglass lenses, at no extra cost.
- Discounts for other add-ons, including Transitions[®] lenses, premium progressive lenses, and premium antireflective coatings.
- Value-added savings,² including 15% to 40% off most extra pairs of glasses, contact lenses, lens treatments, specialized lenses, and various accessories — even after you've used all of your covered benefits.
- Discounts through SpecialOffers@AnthemSM, for LASIK and other products and services that promote health and well-being.

Bundled plan

This plan is only available with a medical and/or dental plan. It cannot be purchased as a stand-alone plan.

Stand-alone plans

If you'd like to buy vision coverage separate from medical and dental, we offer the following plan options:

Individual and family plans

You can choose from these three plans:

- Value
- Plus
- Enhanced

Our comprehensive plans include options for adding the latest lens enhancements for members over age 19.

You can choose from these five plans:

- Progressive Select
- Premier
- Progressive Preferred
- Ultra
- Basic

Pediatric vision benefits

Our Bundled, Value, Plus, and Enhanced plans cover exams, lenses, and frames for children. These add-ons are also available at no extra charge:

- Transitions lenses, to protect eyes from ultraviolet rays
- Polycarbonate lenses, with scratch coating to protect lenses

Savings example

When you have a Blue View Vision plan from Anthem, it can often pay for itself.

	Retail	Member copay	Member cost	Member saves
Exam	\$80	\$20	\$20	\$60
Frame	\$130	None	\$0	\$130
Bifocal lenses	\$80	\$20	\$20	\$60
Scratch coating	\$22	None	\$0	\$22
Progressive premium tier 1	\$140	None	\$85	\$55
Polycarbonate lenses	\$55	None	\$40	\$15
Antireflective premium tier 2	\$100	None	\$68	\$32
Transition lenses	\$110	None	\$75	\$35
Total	\$717			\$409



To compare vision plan benefits, see our detailed charts.

¹ NetMinder data, May 2020.
² Laws in some states may prohibit in-network providers from discounting products and services that are not covered benefits.





For plans
effective
January 1, 2023

Your trusted partner in health

We're here to help you make the best decision for you, your family, and your budget — with guidance, support, and resources every step of the way.

You can sign up today for our dental and vision plans

Apply online: To shop and compare plans, go to anthem.com/ca and select Individual & Family.

Apply on paper: You will need to fill out and sign the application. Then, give it to your Authorized Agent or mail it to us at the address on the form.

▶ **Let us connect you to the right individual coverage.**



This is only a brief description of some plan terms and benefits. Please refer to your Agreement for more complete details, including benefits, limitations, and exclusions.

Sydney Health is offered through an arrangement with Caredon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2020-2022.

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Dental and vision

Benefit charts

2023 Individual and Family Plans

Plans off the Marketplace

Anthem Essential Choice PPO,
Anthem Dental Net 3000D
plans, and Blue View Vision
plans

For plans effective January 1, 2023 

Anthem Essential Choice PPO plans

Cost shares show what the member pays	Essential Choice Bronze	Essential Choice Silver	Essential Choice Gold	Essential Choice Platinum	Essential Choice Incentive
	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network
Diagnostic and preventive	No waiting period	No waiting period	No waiting period	No waiting period	No waiting period
Cleaning, exams, x-rays	0% / 20% coinsurance	0% / 0% coinsurance	0% / 20% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
Basic services	3-month waiting period	3-month waiting period	3-month waiting period	3-month waiting period	No waiting period
Fillings	50% / 50% coinsurance	50% / 50% coinsurance	20% / 40% coinsurance	20% / 20% coinsurance	40% / 40% coinsurance <i>Rewards yearly preventive care by lowering the coinsurance by 10% the following year, up to 20% coinsurance on Basic and 50% on Major.</i>
Brush biopsy	Covered	Covered	Covered	Covered	Covered
Complex and major services (includes teeth whitening)	Not covered	6-month waiting period	6-month waiting period	6-month waiting period	No waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	Not covered	50% / 50% coinsurance	50% / 50% coinsurance	50% / 50% coinsurance	70% / 70% coinsurance <i>Rewards yearly preventive care by lowering the coinsurance by 10% the following year, up to 20% coinsurance on Basic and 50% on Major.</i>
Prosthetics (crowns, dentures, bridges)	Not covered	50% / 50% coinsurance	50% / 50% coinsurance	50% / 50% coinsurance	70% / 70% coinsurance <i>Rewards yearly preventive care by lowering the coinsurance by 10% the following year, up to 20% coinsurance on Basic and 50% on Major.</i>
Orthodontia (children covered up to age 19)	Not covered	Not covered	Not covered	\$150 deductible, then 50% coinsurance <i>\$1,000 lifetime maximum for orthodontia (\$500 per year), after 12 month waiting period.</i>	\$150 deductible, then 50% coinsurance <i>\$1,000 lifetime maximum for orthodontia (\$500 per year).</i>
Dental network	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime
Deductible (per person, unless otherwise noted)	\$50 per person, \$150 per family <i>Deductible is waived for diagnostic and preventive services received in our network.</i>	\$50 per person, \$150 per family <i>Deductible is waived for diagnostic and preventive services received in our network.</i>	\$50 per person, \$150 per family <i>Deductible is waived for diagnostic and preventive services received in our network.</i>	\$50 per person, \$150 per family <i>Deductible is waived for diagnostic and preventive services received in our network.</i>	\$50 per person, \$150 per family <i>Deductible is waived for diagnostic and preventive services received in our network.</i>
Annual maximum (per person)	\$1,000	\$1,000	\$1,500	\$2,000	\$2,500
Annual out-of-pocket limit	None	None	None	None	None
International emergency dental program	Included	Included	Included	Included	Included



Dental HMO Option

With the Dental Net 3000D, you will have affordable dental coverage with no annual maximums, no deductibles and no benefit waiting periods. You will also know what out-of-pocket costs to expect because there are set copays on hundreds of procedures. Plan features include:

- Coverage for approximately 500 dental procedures
- No annual maximum benefit
- No deductible
- No waiting periods
- Easy-to-understand copayments
- Enhanced preventive care
- No claim forms
- A choice of general dentist and specialists

Services	Copays
Office visits	\$10
Diagnostic and preventive services	
Exams	\$0
X-rays	\$0
Cleanings	\$0
Fluoride applications	\$0
Sealants	\$0
Restorative services	
Fillings (one surface resin composite, anterior)	\$20
Fillings (one surface resin composite, posterior)	\$65
Crowns (resin based composite, indirect)	\$55
Endodontic services	
Root canals (anterior)	\$90
Periodontal services	
Scaling and root planing (1 to 3 teeth)	\$35
Prosthodontic services	
Dentures (complete upper or lower)	\$215
Crown (porcelain fused to high noble metal)	\$225
Oral surgery	
Extraction (Erupted tooth or exposed roots)	\$5
Removal of impacted tooth (completely boney)	\$90
Orthodontic services	
Comprehensive treatment children	\$1,695
Comprehensive treatment, adults	\$1,895

The services listed in the above chart are a sample of some of the most frequently asked-about procedures. For complete coverage details, please refer to your policy booklet.

Blue View Vision plans

The Blue View Vision Bundled plan can only be purchased with a medical and/or dental plan. All other Blue View Vision plans listed on these pages can be purchased with or without a medical and/or dental plan.

	Blue View Vision Bundled		Blue View Vision Enhanced		Blue View Vision Plus		Blue View Vision Value	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Eye exam (with dilation as needed)	\$20 copay	\$30 Reimbursement	\$10 copay	\$30 Reimbursement	\$10 copay	\$30 Reimbursement	\$20 copay	\$30 Reimbursement
Frequency	Once every 12 months	Once every 12 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses								
Single vision	\$20 copay	\$25 Reimbursement	\$10 copay	\$25 Reimbursement	\$20 copay	\$25 Reimbursement	\$20 copay	\$25 Reimbursement
Bifocal	\$20 copay	\$40 Reimbursement	\$10 copay	\$40 Reimbursement	\$20 copay	\$40 Reimbursement	\$20 copay	\$40 Reimbursement
Trifocal	\$20 copay	\$55 Reimbursement	\$10 copay	\$55 Reimbursement	\$20 copay	\$55 Reimbursement	\$20 copay	\$55 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Lens add-ons								
Factory Scratch	\$0 copay	Not covered	\$0 copay	Not covered	\$0 copay	Not covered	\$0 copay	Not covered
Tint	\$15 copay	Not covered	\$15 copay	Not covered	\$15 copay	Not covered	\$15 copay	Not covered
Standard anti-reflective coating	\$45 copay	Not covered	\$45 copay	Not covered	\$45 copay	Not covered	\$45 copay	Not covered
Standard progressive lens <i>The copay is in addition to bifocal copay.</i>	\$65 copay	\$40 Reimbursement	\$65 copay	\$40 Reimbursement	\$65 copay	\$40 Reimbursement	\$65 copay	\$40 Reimbursement
Polycarbonate								
Members under age 19	\$0 copay	Not covered	\$0 copay	Not covered	\$0 copay	Not covered	\$0 copay	Not covered
Members age 19 and over	\$40 copay	Not covered	\$40 copay	Not covered	\$40 copay	Not covered	\$40 copay	Not covered
Transitions								
Members under age 19	\$0 copay	Not covered	\$0 copay	Not covered	\$0 copay	Not covered	\$0 copay	Not covered
Members age 19 and over	\$75 copay	Not covered	\$75 copay	Not covered	\$75 copay	Not covered	\$75 copay	Not covered
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Frames	\$130 allowance	\$45 Reimbursement	\$150 allowance	\$45 Reimbursement	\$130 allowance	\$45 Reimbursement	\$130 allowance	\$45 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every other calendar year	Once every other calendar year	Once every other calendar year	Once every other calendar year
Contact lenses Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.								
Elective (conventional and disposable)	\$80 allowance	\$60 Reimbursement	\$150 allowance	\$60 Reimbursement	\$130 allowance	\$60 Reimbursement	\$80 allowance	\$60 Reimbursement
Nonelective	\$0 copay	\$210 Reimbursement	\$0 copay	\$210 Reimbursement	\$0 copay	\$210 Reimbursement	\$0 copay	\$210 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year

Blue View Vision plans

The Blue View Vision Bundled plan can only be purchased with a medical and/or dental plan. All other Blue View Vision plans listed on these pages can be purchased with or without a medical and/or dental plan.

	Blue View Progressive Preferred		Blue View Progressive Select		Blue View Vision Basic		Blue View Vision Premier	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Eye exam (with dilation as needed)	\$10 copay	\$30 Reimbursement	\$10 copay	\$30 Reimbursement	\$20 copay	\$30 Reimbursement	\$10 copay	\$30 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses								
Single vision	\$10 copay	\$25 Reimbursement	\$20 copay	\$25 Reimbursement	\$20 copay	\$25 Reimbursement	\$20 copay	\$25 Reimbursement
Bifocal	\$10 copay	\$40 Reimbursement	\$20 copay	\$40 Reimbursement	\$20 copay	\$40 Reimbursement	\$20 copay	\$40 Reimbursement
Trifocal	\$10 copay	\$55 Reimbursement	\$20 copay	\$55 Reimbursement	\$20 copay	\$55 Reimbursement	\$20 copay	\$55 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Lens add-ons								
Factory Scratch	\$0 copay	Not covered	\$0 copay	Not covered	\$0 copay	Not covered	\$0 copay	Not covered
Tint	\$5 copay	Not covered	\$5 copay	Not covered	\$15 copay	Not covered	\$5 copay	Not covered
Standard anti-reflective coating	\$15 copay	Not covered	\$15 copay	Not covered	\$15 copay	Not covered	\$15 copay	Not covered
Standard progressive lens <i>The copay is in addition to bifocal copay.</i>	\$30 copay	\$40 Reimbursement	\$30 copay	\$40 Reimbursement	\$65 copay	\$40 Reimbursement	\$65 copay	\$40 Reimbursement
Polycarbonate								
Members under age 19	\$40 copay	Not covered	\$40 copay	Not covered	\$40 copay	Not covered	\$40 copay	Not covered
Members age 19 and over	\$10 copay	Not covered	\$10 copay	Not covered	\$10 copay	Not covered	\$10 copay	Not covered
Transitions								
Members under age 19	\$65 copay	Not covered	\$65 copay	Not covered	\$65 copay	Not covered	\$65 copay	Not covered
Members age 19 and over	\$20 copay	Not covered	\$20 copay	Not covered	\$20 copay	Not covered	\$20 copay	Not covered
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Frames	\$150 allowance	\$45 Reimbursement	\$130 allowance	\$45 Reimbursement	\$150 allowance	\$45 Reimbursement	\$180 allowance	\$45 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Contact lenses Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.								
Elective (conventional and disposable)	\$150 allowance	\$60 Reimbursement	\$130 allowance	\$60 Reimbursement	\$150 allowance	\$60 Reimbursement	\$180 allowance	\$60 Reimbursement
Nonelective	\$0 copay	\$210 Reimbursement	\$0 copay	\$210 Reimbursement	\$0 copay	\$210 Reimbursement	\$0 copay	\$210 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year

Blue View Vision plans

The Blue View Vision Bundled plan can only be purchased with a medical and/or dental plan. All other Blue View Vision plans listed on these pages can be purchased with or without a medical and/or dental plan.

	Blue View Vision Ultra	
	In-network	Out-of-network
Eye exam (with dilation as needed)	\$10 copay	\$30 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses		
Single vision	\$10 copay	\$25 Reimbursement
Bifocal	\$10 copay	\$40 Reimbursement
Trifocal	\$10 copay	\$55 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Lens add-ons		
Factory Scratch	\$0 copay	Not covered
Tint	\$5 copay	Not covered
Standard anti-reflective coating	\$15 copay	Not covered
Standard progressive lens <i>The copay is in addition to bifocal copay.</i>	\$65 copay	\$40 Reimbursement
Polycarbonate		
Members under age 19	\$40 copay	Not covered
Members age 19 and over	\$10 copay	Not covered
Transitions		
Members under age 19	\$65 copay	Not covered
Members age 19 and over	\$20 copay	Not covered
Frequency	Once every calendar year	Once every calendar year
Frames	\$200 allowance	\$45 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Contact lenses		
Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.		
Elective (conventional and disposable)	\$200 allowance	\$60 Reimbursement
Nonelective	\$0 copay	\$210 Reimbursement
Frequency	Once every calendar year	Once every calendar year

Limits and Exclusions

Exclusions - Blue View Vision

- Services not listed in the “Your Vision Benefits” section of the Agreement.
- Sunglasses. Sunglass lenses or accompanying frames.
- Any amounts in excess of the maximum benefits stated in the Agreement.
- Premium contact lenses fittings.
- Cosmetic lens options not specifically listed in the “What is Covered” section of the Agreement.
- Any non-prescription lenses, eyeglasses or contacts, or plano lenses or lenses that have no refractive power.
- Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. We also will not cover any contact lenses or eyeglasses required as a result of this surgery.
- Any lost or broken lenses or frames, unless you have reached a new benefit period.
- Services received before your effective date or after your coverage ends.
- Services for which you are not legally obligated to pay, for which you are not charged, or for which no charge is made in the absence of insurance coverage.

Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation law or similar law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to any workers' compensation law or similar law, we will provide the benefits of this plan for such condition, subject to our right to a lien or other recovery applicable law.

Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

- Treatment or services rendered by non-licensed providers and treatment or services for which the provider of services is not required to be licensed.
- Services of relatives.
- Orthoptics or vision training and any associated supplemental testing.
- Missed or cancelled appointments.
- Services or supplies combined with any other offer, coupon or in-store advertisement.



Primary applicant name: _____

Welcome

California Individual Application

Thanks for choosing us. We're glad you're here.

If you have any questions while filling out this form, give us a call at 1 (877) 567-1804. But if you've worked with an agent or broker, contact them first.

About this form

Use this form to apply for **new** dental and/or vision coverage or to **change** existing coverage with Anthem Blue Cross (Anthem).

You can apply for, or change coverage:

1. During the annual Open Enrollment period

Your coverage will start based on when we receive your complete application. The earliest date coverage can start is January 1st.

If we get your application:

- Between November 1 through December 15, coverage starts January 1.
- Between December 16 and January 31, coverage starts February 1.

2. When you have a Special Enrollment period due to a qualifying event

When you're done with this form, fill out **Appendix A: Special Enrollment**, which includes information about qualifying events and when coverage starts.

For new dental and vision:

- You can apply any time of year.
- Your coverage will start based on when we receive your complete application. Coverage starts the 1st day of the month after the date we receive your complete application.

Tips for filling out this form

- Answer all questions. Please print clearly using blue or black ink only.
- Please submit all pages.
- You can also apply online at anthem.com/ca.
- If you're enrolling in a dental HMO plan, you must choose a Primary Care Dentist (PCD). View a list of dentists for your plan on anthem.com/ca or call us. If you don't choose a PCD, we'll pick one located close to you.
- Please include your payment. We can't complete your application without your first month's premium payment. Without it, your enrollment will be delayed. Don't worry though – we won't charge your card or cash your check or money order until you've been enrolled.

Some frequently asked questions

1. Do I need to include a payment?

Yes. We can't process your application without your first month's premium payment. Without it, your enrollment will be delayed. We won't charge your card or cash your check or money order until you've been enrolled.

2. Why do you need my Social Security Number (SSN)?

The IRS requires us to collect it. It won't be shared unless required by law.

Anthem Blue Cross is the trade name of Blue Cross of California.
Independent licensee of Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

California Individual Application

Please indicate the reason for this application:

- ☐ Open Enrollment
☐ Special Enrollment Period (also complete Appendix A)

Step 1: Who is applying?

Primary Applicant

☐ New coverage

- ☐ Change coverage
☐ Add dependent to existing coverage

Subscriber
ID no. _____

Last name (legal name)		First name (legal name)		M.I.	Social Security Number - -	
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm/dd/yyyy) / /		County (for home address)	
Home address (not a P.O. Box)			City		State	ZIP
Billing address (optional - if different than home address)			City		State	ZIP
Mailing address (optional - if different than home address)			City		State	ZIP

Email address:

Applies only to Dental Net DHMO plans: I agree to receive my plan-related communications for myself and any dependents, either by email or electronically. This may include my certificate of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my benefits. I will make sure Anthem has my most up to date email. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Anthem. I (or my enrolled dependents) will update our communication preferences by going to anthem.com/ca or calling Member Services at 1 (877) -567-1804.

For Dental PPO, Vision, Life and Disability plans Anthem will deliver plan materials and related items by mail.

Primary phone

☐ Applicant DOES speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a "Statement of Accountability. (Appendix B).

Preferred written language	<input type="checkbox"/> English (ENG)	<input type="checkbox"/> Spanish (SPA)	<input type="checkbox"/> Chinese (ZHO) (C/M)
	<input type="checkbox"/> Korean (KOR)	<input type="checkbox"/> Tagalog (TGL)	<input type="checkbox"/> Vietnamese (VIE)
	<input type="checkbox"/> Other (write-in) _____		
Preferred spoken language	<input type="checkbox"/> English (ENG)	<input type="checkbox"/> Spanish (SPA)	<input type="checkbox"/> Chinese (ZHO) (C/M)
	<input type="checkbox"/> Korean (KOR)	<input type="checkbox"/> Tagalog (TGL)	<input type="checkbox"/> Vietnamese (VIE)
	<input type="checkbox"/> Other (write-in) _____		

PCD (DHMO only)	Dental group ID/PCD ID (DHMO only)	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
------------------------	---	--

Coverage(s) selected ☐ Dental ☐ Vision

To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.

Spouse or Domestic Partner

Last name (legal name)	First name (legal name)	M.I.	Social Security Number - -
Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm/dd/yyyy) / /	
PCD (DHMO only)	PCD ID (DHMO only)	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Coverage(s) selected <input type="checkbox"/> Dental <input type="checkbox"/> Vision To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.			

Dependent Child

Children must be under age 26.

Children over the age of twenty-six (26) may be eligible for coverage as a dependent if they are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and chiefly dependent upon the policyholder or subscriber for support and maintenance. To qualify as an overage dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage.

Last name (legal name)	First name (legal name)	M.I.	Social Security Number - -
Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm/dd/yyyy) / /	
PCD (DHMO only)	PCD ID (DHMO only)	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Coverage(s) selected <input type="checkbox"/> Dental <input type="checkbox"/> Vision To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.			

Dependent Child

Last name (legal name)	First name (legal name)	M.I.	Social Security Number - -
Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm/dd/yyyy) / /	
PCD (DHMO only)	PCD ID (DHMO only)	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Coverage(s) selected <input type="checkbox"/> Dental <input type="checkbox"/> Vision To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.			

Dependent Child☐ **Check here if you have more dependents.** Print an extra copy of this page and attach to your application.

Last name (legal name)	First name (legal name)	M.I.	Social Security Number - -
Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm/dd/yyyy) / /	
PCD (DHMO only)	PCD ID (DHMO only)	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Coverage(s) selected <input type="checkbox"/> Dental <input type="checkbox"/> Vision To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.			

Eligibility

The answer to this question is needed to determine your eligibility.

Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? (not just pending disposition of charges)
☐ No ☐ Yes **If yes, who?**

Step 2: What coverage would you like?

Dental Plans

Dental coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a dental plan if you want to buy coverage for more than these Pediatric Dental Essential Health Benefits.

Dental HMO applicants must reside in one of these counties to enroll: Alameda; Contra Costa; El Dorado; Fresno; Kern except for Delano, Mojave, Taft, and Tehachapi; Kings; Los Angeles; Marin; Monterey; Orange; Placer; Riverside; Sacramento; San Bernardino except for Twenty-Nine Palms and Vicinity, and Yucca Valley; San Diego; San Francisco; San Joaquin; San Luis Obispo; San Mateo; Santa Barbara; Santa Clara; Santa Cruz; Solano; Sonoma; Tulare; Ventura.

Dental plan options

Dental PPO

- ☐ Essential Choice Bronze (5SKJ)*
- ☐ Essential Choice Silver (5SKK)*
- ☐ Essential Choice Gold (5SKL)*
- ☐ Essential Choice Platinum (5SKM)*
- ☐ Essential Choice Incentive (5SKN)*

Dental HMO (DHMO)

- ☐ Dental Net 3000D (3T9D)**

* These products are issued by Anthem Blue Cross Life and Health Insurance Company and are regulated by the California Department of Insurance.

** These products are issued by Anthem Blue Cross and are regulated by the California Department of Managed Health Care.

Prior & other dental coverage

Name of person covered (Last, First, M.I.)	Coverage (check all that apply)	Insurer name	Policy ID no.	Dates (if applicable) (mm/dd/yyyy)
	<input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: End:
	<input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: End:
	<input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: End:
	<input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: End:
	<input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: End:

Vision Plan

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a vision plan if you want to buy coverage for more than these Pediatric Vision Essential Health Benefits.

Vision plan options

- ☐ Blue View Vision Basic (5LBZ)
- ☐ Blue View Vision Premier (5LEZ)
- ☐ Blue View Vision Ultra (5LDK)
- ☐ Blue View Progressive Select (5LAP)
- ☐ Blue View Progressive Preferred (5LAK)
- ☐ Blue View Vision Plus (2SU7)
- ☐ Blue View Vision Value (2SU8)
- ☐ Blue View Vision Enhanced (2SU6)
- ☐ Blue View Vision Bundled (1RYD)

Step 3: Please read and sign

Important legal information

All Applicants

I, the undersigned, understand that under the (Anthem) plan/policy in which I am enrolling, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1 (855) 383-7247 with any questions about the use of network providers and the financial impact of using out-of-network providers.

HIV Testing PROHIBITED:

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

I understand that:

- I must include my first premium payment with this application, but that does not mean coverage has been processed. I'm applying for the coverage I chose in Step 2. Anthem has the right to accept or decline this application. If my application is denied, my bank account or credit card will not be charged, and if I paid with a money order, it will be returned to me.
- I'm responsible to let Anthem know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- Check payments may be handled as Automated Clearinghouse (ACH) debit transactions. That means if I pay by check, the paper check will be destroyed and the debit payment will appear on my bank statement. My check won't be given to my financial institution or sent back to me. This does not mean I will be enrolled in an automatic debit process to pay my premium. Any resubmissions due to insufficient funds may also be electronic. All checking transactions will remain secure, and my payment by check means I agree to these terms.
- I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and me.
- By providing a phone number, I agree and consent that Anthem and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.
- I'm applying for individual dental and/or vision coverage which is not part of any employer sponsored plan and I'm responsible for all of the premium payments and making sure that all premiums are paid on time.
- I certify that each Social Security Number listed on this application is correct.
- My Domestic Partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.

I represent that I have read the Important Legal Information section, and I agree to the coverage conditions. I represent the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem in accepting this application. Within the first 24 months following issuance of this policy, any act or practice that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits or cancellation of my coverage(s).

I sign this application for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative. This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE AGREEMENT OR ANY OTHER ISSUES RELATED TO THE AGREEMENT AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. FOR CLAIMS THAT EXCEED THE JURISDICTION OF THE SMALL CLAIMS COURT THAT ARE SUBJECT TO BINDING ARBITRATION UNDER THIS AGREEMENT, CALIFORNIA HEALTH AND SAFETY CODE SECTION 1363.1 AND INSURANCE CODE SECTION 10123.19 REQUIRE SPECIFIED DISCLOSURES IN THIS REGARD: IT IS UNDERSTOOD THAT ANY DISPUTE AS TO MEDICAL MALPRACTICE, THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THIS CONTRACT WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENCE OR INCOMPETENTLY RENDERED, WILL BE DETERMINED BY SUBMISSION TO ARBITRATION AS PERMITTED AND PROVIDED BY FEDERAL AND CALIFORNIA LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. BOTH PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION. YOU AND ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. IF YOUR POLICY IS SUBJECT TO 45 CFR 147.136, THIS AGREEMENT DOES NOT LIMIT YOUR RIGHTS TO INTERNAL AND EXTERNAL REVIEW OF ADVERSE BENEFIT DETERMINATIONS AS REQUIRED BY THAT LAW. ENFORCEMENT OF THIS ARBITRATION CLAUSE, INCLUDING THE WAIVER OF CLASS ACTIONS, SHALL BE DETERMINED UNDER THE FEDERAL ARBITRATION ACT ("FAA"), INCLUDING THE FAA'S PREEMPTIVE EFFECT ON STATE LAW. BY SIGNING, WRITING OR TYPING YOUR NAME BELOW YOU AGREE TO THE TERMS OF THIS AGREEMENT AND ACKNOWLEDGE THAT YOUR SIGNED, WRITTEN OR TYPED NAME IS A VALID AND BINDING SIGNATURE.

Please sign below

	Primary Applicant (or legal representative)	Date (mm/dd/yyyy)
	Spouse/Domestic Partner (or legal representative)	Date (mm/dd/yyyy)
	Dependent Child (age 18 or over)	Date (mm/dd/yyyy)
	Dependent Child (age 18 or over)	Date (mm/dd/yyyy)
	Dependent Child (age 18 or over)	Date (mm/dd/yyyy)

Did an agent or broker help you?

☐ Yes ☐ No If yes, make sure they fill out this section.

Agent (or Broker) Certification

All fields required.

I certify to the best of my knowledge and belief, the responses herein are accurate.

- ☐ I have not had any interactions whatsoever with this applicant either by phone, e-mail or in person and did not provide any information, advise or assist the applicant in any manner in providing answers or responses to any questions in the application.
- ☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars (\$10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

Agent/Broker signature

Date (mm/dd/yyyy)

Agent name (please print clearly)

*(A) Writing Agent TIN/SSN (encrypted TIN is ok)

** (B) Writing Agent/Agency/ TIN (encrypted TIN is ok)

Agent address

City

State

ZIP

Agent phone no.

Agent fax no.

Agent email

Field (A)** – If you are a Direct Agent, provide your Writing Agent TIN/SSN. *Field (B)** - If this policy is sold through an Agency without a Writing Agent, enter the selling Agency TIN in Field (A) and Field (B); If you are a Writing Agent and this policy is sold through an Agency, enter the Writing Agent TIN/SSN in Field (A) and the selling Agency TIN in Field (B).

Here's what's next.

- 1) Can you check a few items? When illegible or missing, they can cause enrollment delays.
 - Your name and address is clear and complete.
 - You've included your first month's premium payment.
 - Everyone 18 and older applying for coverage signed this form
 - Please make sure you submit all the pages of the application, including this page, even if you don't have an agent.
 - If enrolling due to a qualifying event, you've completed Appendix A: Special Enrollment.
- 2) All good? Send this to us by mail to Anthem Dental, P.O. Box 659960, San Antonio, TX 78265-9146 or by fax to 1 (800) 848-2512.
- 3) We'll be in touch in the next few weeks (or sooner). If you have questions before then, call us at 1 (877) 567-1804.

Thank you!

Appendix A: Special Enrollment

If you're an existing member and wish to change coverage or add or remove a dependent(s), please fill out this section along with your application.

Qualifying event date	
Date of qualifying event (mm/dd/yyyy) / /	For Loss of Coverage, this is the last date of existing or prior coverage. For all other events, please enter the date based on the qualifying event.

You must apply for coverage within 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
<input type="checkbox"/> 1. Marriage or Domestic Partnership Got married or in a domestic partnership that becomes eligible for coverage (see step 3 for description of eligibility).	First day of the month after we receive your complete application
<input type="checkbox"/> 2. Birth or adoption Had a baby, adoption of a child or placement of a child with you for adoption	Select an effective date: <input type="checkbox"/> Same as the event date <input type="checkbox"/> First day of the month after we receive your complete application <input type="checkbox"/> Based on when we receive your complete application* <input type="checkbox"/> First day of month after the event date
<input type="checkbox"/> 3. Court order or guardianship Required by a court order to provide an eligible child(ren) coverage, including a child support order, filed an application for appointment of guardianship of a child or appointment of guardianship of a child	Select an effective date: <input type="checkbox"/> Same as the event date <input type="checkbox"/> Based on when we receive your complete application*
<input type="checkbox"/> 4. Death Death of a family member enrolled under current coverage	Select an effective date: <input type="checkbox"/> First day of the month after we receive your complete application <input type="checkbox"/> Based on when we receive your complete application*
<input type="checkbox"/> 5. Returning from active duty Member of the Reserve Forces of the U.S. military returning from active duty or member of the California National Guard returning from active duty under Title 32 of the U.S. Code	Based on when we receive your complete application*
<input type="checkbox"/> 6. Loss of coverage: Lost or will lose Minimum Essential Coverage: Involuntary loss of coverage (loss of minimum essential coverage includes loss of eligibility of coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, permanent move, etc. Loss of eligibility for coverage does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).	First day of the month after we receive your complete application

* If the coverage date is based on when we receive your complete application, then if we receive it:

- Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
- Between the 16th and the last day of the month, coverage starts the 1st day of the second following month.

You must apply for coverage within 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
<p>7. Permanent move</p> <p><input type="checkbox"/> Moved to U.S. from a foreign country or a U.S. territory</p> <p><input type="checkbox"/> Permanent move to a new service area (within the U.S.).</p> <p><input type="checkbox"/> 8. Non-calendar renewal</p> <p>Current policy does not renew on a calendar year basis (renews on a date other than January 1)</p> <p><input type="checkbox"/> 9. Jail or prison</p> <p>Released from jail or prison (incarceration)</p>	Based on when we receive your complete application*

* If the coverage date is based on when we receive your complete application, then if we receive it:

- Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
- Between the 16th and the last day of the month, coverage starts the 1st day of the second following month.

Almost there! We may need a bit more info.

We need supporting documentation for most qualifying events, such as a letter or official form from the source (employer, state or federal agency, for example) to confirm the qualifying event occurred. It should also include the date the event happened, and the names of all applicants affected. If you're applying because you've lost coverage, we need supporting documentation with the reason coverage was lost. In all cases, we might need additional documentation to confirm eligibility.

Give us or your agent a call if you have any questions.

Appendix B: Statement of Accountability

Statement of Accountability

Fill out when applicant cannot complete application.

Note: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, _____, personally read and completed this Individual Application for the applicant named below because:

- ☐ Applicant does not read English
- ☐ Applicant does not speak English
- ☐ Applicant does not write English
- ☐ Applicant is Limited English Proficient
- ☐ Other (explain) _____

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the

☐ Applicant or by: _____

Language interpreted

☐ Spanish ☐ Chinese ☐ Korean ☐ Tagalog ☐ Vietnamese ☐ Other _____

I also interpreted and fully explained the "Important legal information" and the "Payment Method".

Signature of interpreter (required)

Date (mm/dd/yyyy) (required)

I confirm that the application was interpreted on my behalf

Signature of applicant (required)

Date (mm/dd/yyyy) (required)

Applicant/Member name	Primary applicant's Social Security number
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I, the applicant am responsible for monthly payments to Anthem. I authorize Anthem to debit the bank account listed or charge the credit/debit card listed for my first monthly payment on or after the day that my coverage is approved. By signing this form, I understand that the amount of the first payment may change from what I was told because my coverage has not been approved yet. In addition if I select Option 1 or Option 2 below, I understand that my future payments may vary as a result of changes(s) I make once enrolled, including but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified according to my plan/policy. In addition, I understand if changes I make are close to the auto withdrawal date, Anthem may not be able to notify me before the withdrawal is made. **I agree to pay any service charge that Anthem may bill me because the debit/charge was not honored.** I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Please choose how you want to pay your monthly payments for all of your plans. Put a check in the box for either Option 1, Option 2 or Option 3.

☐ **Option 1 Bank Account Authorization: Have your first and future monthly payments automatically deducted from your bank account.**

All of your monthly payments will be taken out of the bank account you check below.

Checking account: ☐ Business ☐ Personal

Savings account: ☐ Business ☐ Personal

Enter the requested debit date from your bank account (1st to 6th of each month). If no date is requested your monthly payments will be debited on the first of each month.

Write the routing and account numbers that are on your check here: →

MEMO	
123456789	1234567890123 1175

9-digit bank routing number	Bank account number
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I authorize Anthem to automatically debit the bank account listed above each month to make my monthly payments. I agree that **Anthem's rights with each debit are the same as if the debit was a check that I signed.** I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem to automatically debit my account (and to make corrections to previous debits). This authority stays in effect until I let Anthem know that I no longer want them to debit my account by giving them a 30-day advance written notice. I understand that if my bank does not allow Anthem to debit my account for any reason, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Authorized signature (as it appears on bank's records) X	Printed bank account holder's name (as it appears on account)	Date (MM/DD/YY)
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☐ **Option 2 Credit/Debit Card Authorization: Have your first and future monthly payments automatically charged to your credit/debit card.**

Complete the information below

Enter the requested charge date for your credit/debit card (1st to 6th of each month).

I authorize Anthem to automatically charge my credit/debit card listed below each month to make my monthly payments. I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem to charge my credit/debit card until I let them know that I no longer want them to charge my credit/debit card by giving them a 30-day advance written notice. I agree that Anthem, in honoring the monthly payments charged to my credit/debit card, is not responsible for any fees charged by my bank. I understand if that if any Anthem credit/debit transaction is not honored, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Anthem accepts ☐ Visa or ☐ Mastercard (Note to applicant: Please check one.)

Card number	Expiration date <input type="text"/> (MM/YY)	
Billing address for this credit/debit card	City	Zip code
Authorized signature (as it appears on card) X	Printed card holder's name (as it appears on card)	Date (MM/DD/YY)

See page two for Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.

Applicant/Member name	Primary applicant's Social Security number <div style="border-bottom: 1px solid black; width: 100px;"></div>
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☐ **Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.**

Choose one of the ways below that you would like to pay only your first monthly payment.

☐ Check (enclose your paper check with application) ☐ Electronic check (fill out section A below) ☐ Credit/Debit card (fill out section B below)

A. **Electronic check:** Instead of sending us a paper check, you can use an electronic check that allows Anthem to take the money right from your bank account to make your first payment on the day that your coverage is approved. You will not get the check back from your bank. (We will not keep this information on file or use it for any future payments.) Please fill out this information.

Printed account holder name	Routing number	Account Number	Amount of first payment \$
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B. **Credit/Debit card:** I allow Anthem to charge the credit or debit card I listed below one time for my first monthly payment. This payment will cover the first monthly payment for all of the plans I have with Anthem.

Anthem accepts ☐ Visa or ☐ Mastercard (Note to applicant: Please check one.)

Card number	Expiration date <div style="border-bottom: 1px solid black; width: 40px;"></div> / <div style="border-bottom: 1px solid black; width: 40px;"></div> (MM/YY)
Billing address for this credit/debit card	City
	Zip code

I authorize Anthem to debit/charge the bank account or credit/debit card listed above **to make my first monthly payment only.**

I agree that Anthem will not have to pay any fees that my bank may charge because my electronic check or credit/debit card was rejected even if I can no longer continue coverage. I understand that **this is a one-time payment and that I am responsible for making sure Anthem receives my future monthly payments after this first payment.**

Authorized signature (as it appears on bank account/card) X	Printed bank account/card holder's name (as it appears on account/card)	Date (MM/DD/YY) <div style="border-bottom: 1px solid black; width: 100px;"></div>
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Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Get help in your language

Language Assistance Services



Curious to know what all this says? We would be too. Here's the English version:

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما لمساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող եք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese

重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwv tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要: この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer

សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចចូលរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសាសាបសំអ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ
សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721 (TTY/TDD: 711)

Korean

중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੱਖੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ।
(TTY/TDD: 711)

Russian

ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้
เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย
หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

2023 Plan Year

Anthem Essential Choice PPO and HMO dental plan rates

INDIVIDUAL DENTAL PREMIUMS IN CALIFORNIA

For policies with effective dates
January 1 through December 31, 2023

Routine dental checkups are important, not only for the teeth but for overall health, too. These exams can help decrease the risk of health conditions in the mouth, such as cavities and gum disease, and also help dentists spot signs of other health conditions.* With your Anthem plan, you have access to one of the largest dental networks in the country, to help make it easier to take care of your dental health.

As part of your plan, you receive 100% coverage for preventive care, including regular dental cleanings, exams, and X-rays, when you receive care from a dentist in your plan's network. All plans cover preventive care with no waiting periods, so you can use your benefits right away.

Our Essential Choice PPO dental plans feature higher annual benefit maximums (the amount your plan will pay for dental care). You can carry over part of your unused dental benefits to the next year if you do not use all of them. Over time, this means you could double your annual maximum benefit. Essential Choice PPO dental plans also have shorter waiting periods than traditional plans for basic and major services, and our Incentive plan does not have any waiting periods.

The child/children rates shown in the charts below are defined as dependent children ages 0-18. Any enrollees age 19 and over use the adult rates, including dependent children over the age of 18. For a family, each adult (including dependent children ages 21-26) are rated first, and then up to the three eldest children ages 0-20. You will not be charged premiums for more than three children between the age of 0-20, even if there are more children covered by the plan.

Note that the charts below provide pricing for many of the most common family units. For other combinations, please talk to your broker or sales representative.

Anthem Essential Choice PPO Dental Plan

	Bronze		Silver		Gold		Platinum		Incentive	
	Under Age 65	Age 65 and over	Under Age 65	Age 65 and over	Under Age 65	Age 65 and over	Under Age 65	Age 65 and over	Under Age 65	Age 65 and over
Individual	\$25.20	\$28.25	\$39.75	\$44.55	\$50.75	\$56.85	\$60.50	\$67.80	\$57.75	\$64.70

Anthem Dental Net 3000D DHMO monthly payments

Dental HMO applicants must reside in one of these counties to enroll: Alameda, Contra Costa, El Dorado, Fresno, Kern (except for the cities of Mojave and Taft), Kings, Los Angeles, Marin, Monterey, Orange, Placer, Riverside, Sacramento, San Bernardino (except for the cities of Twenty-Nine Palms and Yucca Valley), San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Tulare and Ventura.

Single	\$16.06
Two People (member and spouse or member and child)	\$32.12
Family (three or more) (member, spouse, and child; or member and children)	\$52.20

Blue View VisionSM monthly payments

This vision rider is available when purchased with any Anthem medical and/or dental plans.

Individual	\$7.61
Individual + one	\$13.31
Family	\$21.30



*Academy of General Dentistry. Know Your Teeth: Oral Warning Signs Can Indicate Serious Medical Conditions (accessed August 2020): [knowyourteeth.com](https://www.knowyourteeth.com).

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Blue View Vision: Individual vision premiums for California

For policies with effective dates from January 1 through December 31, 2023

Eye exams are good for more than just checking your vision. They're also an important part of caring for your overall health. Eye doctors can often find signs of conditions such as diabetes, high blood pressure, and high cholesterol. With your Blue View Vision plan, you have options for eye care and prescription eyewear needs. Our network is one of the largest in the country, so you can choose from more than 40,000 eye doctors and other eye care professionals at more than 30,000 locations.* That includes independent eye doctors, and regional or national stores, such as LensCrafters® and Target Optical®. You will also have 24/7 access to online retailers, including 1-800 CONTACTS®.

Monthly premiums

Vision Plan	Three Tier Structure		
	Individual Only	Individual + 1	Family
Blue View Vision Enhanced	\$18.53	\$32.43	\$51.89
Blue View Vision Plus	\$14.60	\$25.55	\$40.89
Blue View Vision Value	\$12.23	\$21.40	\$34.24
Blue View Vision Progressive Preferred	\$24.93	\$47.37	\$72.63
Blue View Vision Select	\$22.30	\$42.36	\$64.95
Blue View Vision Basic	\$18.99	\$36.08	\$55.31
Blue View Vision Premier	\$23.19	\$44.06	\$67.55
Blue View Vision Ultra	\$25.66	\$48.75	\$74.74

* NetMinder data, May 2020.

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