CALIFORNIA: Individual and Family

Your Health Plan Guide

Bronze, Silver, Gold, Platinum and Minimum Coverage Tiered PPO plans
offered by Anthem Blue Cross
Certified by Covered California

Looking for a new health plan? We can help.

Pathway X - PPO Tiered Network serving San Francisco county. Plans issued by Anthem Blue Cross .

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Why Anthem?

Health plans don't have to be complicated.

We understand that every individual and family is unique. That's why we offer many high-quality, affordable plan options for different health care needs and budgets. Our goal is not just to be there when you're sick, but also to help you stay well – at every stage of life.

With Anthem Blue Cross (Anthem), you can count on:

- A strong national network.
- Competitive pricing.
- A brand you can trust.
- Local presence where you live and work.
- Resources and support for your health care goals.
- Convenient online tools, including LiveHealth Online.
- A simple enrollment process.
- Dedicated customer service.
- All your benefits, including dental and vision, from one source.

Check out our guide to learn about all that we offer, including tiered preferred provider organization (PPO), dental, vision and minimum coverage (catastrophic) plans. We're confident we can help find the right fit for you!

It's time to expect more of health care plans.

Anthem is right there with you.

You want the best value your health care dollars can buy. And in California, we deliver like no one else - through our networks and our experience.

41,245 PHYSICIANS[1]

329 HOSPITALS[1]

78 OF SERVICE[2]

[1] Based on Internal Provider Data Report, 2015. Medical doctors also includes Doctors of Osteopathic Medicine. Hospitals includes General Acute Care Hospitals; Surgical Services (Ambulatory Surgical Centers and Outpatient Hospitals) & Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital).
[2] Based on Internal Data, 2015.

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What we cover

All our plan options have one major goal — to help you stay healthy and find the quality coverage you need, when you need it. That's why, no matter which plan you choose, you're covered from preventive care to emergencies and everything in between!

Core benefits

Our plans include the essential health benefits (EHBs) mandated by the Affordable Care Act (ACA):

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services, like going to the emergency room (ER) or urgent care center, when medically necessary
- Hospitalization and inpatient services, such as surgery and the care you get when you stay overnight in a hospital
- Pregnancy, maternity and newborn care (care before and after your baby is born)
- Mental health and substance abuse disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drug coverage
- Rehabilitative and habilitative services and devices (services and devices, like hospital beds, crutches, wheelchairs and oxygen tanks, to help people with injuries, disabilities or chronic health conditions gain or recover mental and physical skills)
- Laboratory and radiology services, including blood work, screenings and X-rays
- In-network preventive care services,[1] including wellness exams, immunizations, screenings and chronic disease management resources
- Pediatric dental coverage for children up to age 19, benefits include:
  - Diagnostic and preventive services (cleaning, exams, X-rays) — no extra cost to you, not subject to deductible on most plans
  - Basic services (fillings) — 50% coinsurance
  - Endodontic, periodontal and oral surgery —50% coinsurance
  - Medically necessary orthodontia — 50% coinsurance
  - Access to any provider in the Dental Prime network
  - Shared out-of-pocket maximum with medical plan, and no annual maximum

Take care of yourself with no-cost, in-network preventive care

With Anthem, you pay $0 out of pocket for covered in-network preventive services. So you can stay on top of your health care and your finances at the same time![1]

- Pediatric vision coverage for children up to age 19, benefits include:
  - Yearly vision exams, glasses or contact lenses
  - Glasses with Transitions® lenses (to protect eyes from UV rays) and polycarbonate lenses and/or scratch coating (to protect lenses from damage) at no extra cost
  - Access to any provider in the Blue View Vision℠ network, with retailers such as 1-800-CONTACTS®, LensCrafters® and Target Optical®

[1] Nationally recommended preventive care services from in-network providers have no copay 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.

Prescription drug benefits

Our prescription drug benefits help you cover the cost of your medications and get them to you in the most convenient way possible.

Here's what you need to know:

Select Drug List (formulary)

All our prescription drug plans have a formulary, a list of preferred generic and brand-name prescription drugs. This is called the Select Drug List. It includes the most commonly used Food and Drug Administration-approved drugs covered by your plan.

Prescription drug tiers

Every drug on the Select Drug List is assigned to a certain tier (or level) based on cost, the availability of over-the-counter alternatives, clinical information and other drugs in that class that may be used to treat the same or similar condition. The list tells you what tier your drug is in and details about its cost, which usually goes up the higher the drug tier. If your medication is in a higher tier, you may want to talk to your doctor about lower-cost options.

For more information about your prescription drug benefits, go to anthem.com/ca:

- To find out if your medication is covered, check out our drug list at anthem.com/ca/selectdrugtier4.
- To learn more about pharmacy processes and clinical edits, such as prior authorization, step therapy, quantity limits and dose optimization, visit anthem.com/ca/pharmacyinformation.
- To see if your pharmacy is in our network, select ***Find a Doctor***. Then, select California and find the plan/network (Pathway X - PPO Tiered) you're considering Choose **Pharmacy** and the location.

We understand missing one dose of your maintenance medication can impact your health. Home delivery is a great way to make sure you get your refills when you need them. Plus, with home delivery, you can save on copays for 90-day supplies.*

Save with home delivery pharmacy

Anthem wants to help lower the cost of your prescription drugs, improve your overall health and deliver top-notch customer service. We offer home delivery of your medicines right to your door.

If you take medicines for ongoing conditions like diabetes, high cholesterol and high blood pressure, you choose whether to use home delivery or continue with your retail pharmacy. **It's important to note, you'll need to let us know your choice before your third refill of any medicine at a retail pharmacy. If you don't choose, your prescriptions will no longer be covered until you notify us.**

Using home delivery can help you save money. Depending on your plan, many 90-day supplies of generic medicines from home delivery cost the same as two 30-day supplies from a retail pharmacy. You could save up to four copays a year on one drug.* Plus, standard shipping is free!

* The home delivery pharmacy cost shares for Tier 1 drugs are 2 x the retail copay and for Tier 2 drugs are 2.5 x the retail copay when the plan has retail pharmacy copays. Cost savings do not apply to coinsurance plans.

Dental benefits

We offer an Individual and Family dental plan to fit your health care needs and budget:

- Anthem Family Dental PPO

Anthem can help you get the dental care you need for better overall health. Our dental plan includes 100% coverage for exams, cleanings and X-rays. Plus, there are benefits for fillings, crowns, root canals, oral surgery and orthodontia. To see more detailed benefits, go to the **Dental stand-alone plan benefit chart** section.

The medical + dental advantage
Coordinating medical and dental plans can result in better care — delivered sooner and at a lower cost. Plus, you enjoy the convenience of having only one ID card and one bill when you purchase all your coverage from Anthem.

How to choose a plan

Figuring out what you need

Choosing the right health care plan can be challenging. To help you pick, consider the questions below. And remember, your Anthem Authorized Agent is here to provide answers and give advice.

Things to think about:

- **Does the plan meet your likely coverage needs?** How often do you see doctors and specialists? What prescription medications do you take regularly? Are you planning any procedures this year?
- **Is staying with your current doctor(s) important?** If the answer is yes, then you can use our **Find a Doctor** tool at anthem.com/ca to check that your doctor is in our network. If you choose one of our Tiered PPO plans and your doctor is not in the network, you'll still have coverage; however, you have to decide whether you want to pay higher out-of-network cost shares. Sticking with in-network doctors can save you a lot of money.
- **What is your family's budget?** You may prefer to pay more monthly in premiums and less out of pocket for services, like doctor visits or lab work. Or you may want to pay higher out-of pocket costs for services in exchange for a lower fixed — and predictable — monthly premium. It depends on how well you think your budget can handle the unexpected. Our plans offer different deductible, coinsurance and copay options, so you can find the level of cost sharing that works for you.
- **Is a Minimum Coverage (also known as Catastrophic) plan an option?** If you're under age 30 or are 30 years of age or older with an approved hardship exemption from Covered California, you may qualify for a high deductible, low premium, Minimum Coverage plan. Minimum coverage plans can help protect you from worst-case scenarios like serious accidents or illnesses.

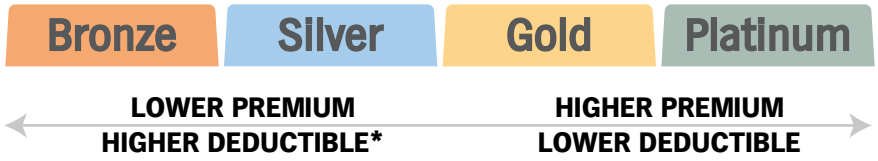
Consider a health savings account (HSA)

Contributing to an HSA can help your money go further. An HSA is a savings account you can open when you have a qualified high-deductible health plan (HDHP). You set up the account through a bank and fund it with post-tax dollars. That money can be used to pay for health care expenses, including prescriptions. Plus, you can claim your HSA contributions as tax deductions even if you don't itemize them on Form 1040. HSA-compatible health care plans work with or without this savings account; the choice is yours.

Our HSA-compatible plans include HSA in the plan name. Check with your tax advisor to see if an HSA plan is right for you. You can also learn more about HSAs from the HSA flier included with this brochure.

What are your plan choices?

Plan Levels



* This does not apply to Silver cost-share reduction /subsidy plans. Silver cost-share reduction plans / subsidy plans are only available for Qualified Health Plans purchased through Covered California. Anthem Blue Cross is a Qualified Health Plan issuer that offers such plans through Covered California. Only your state exchange can determine eligibility for financial help.

How your plan might work

With most health care plans, you pay a monthly fee called a premium; then, you share some of the cost of care with your health insurance company. **With Anthem, you choose the level of cost sharing that works for you.**

Here's an example: *Meet John**

To show you how your health plan might work, we'd like to introduce you to "John." The cost-share amounts used in this example may not apply to the plan you're interested in. Be sure to look at the actual benefits for each plan when you're deciding.

John's story

After injuring his knee in a soccer game, John calls his doctor. He chooses a provider in our network, which saves him the most money. John gets Anthem negotiated rates because he uses in-network providers. **Below, you'll see how John's benefits work, his treatment costs and why it's important to have health insurance:***

John's health plan has the following benefits:

- $35 copay for doctor visits
- $2,000 deductible
- 30% coinsurance
- $5,000 out-of-pocket limit

Copay
On some plans, you pay a fixed-dollar amount or copay for certain services. For example, you may have a $35 copay for in-network doctor visits.

Let's take a closer look at John's doctor visit:

- *Doctor visit cost (without insurance):* $200
- *Anthem's negotiated rate:* $140
- *Anthem pays:* $105
- ▶ ***John paid:* $35** (This is his plan's copay for doctor office visits.)

Deductible
You pay this amount for covered medical services each calendar year, from January 1 through December 31. Your deductible starts over each calendar year.

Covered services that apply to the deductible include lab work, X-rays, anesthesia and surgeon fees. Covered in-network preventive services have no deductible, coinsurance or copay.

Here's what happens when John's doctor orders an approved magnetic resonance imaging (MRI) of the knee and recommends surgery:

MRI

- *MRI cost (without insurance):* $1,500
- *Anthem's negotiated rate:* $1,000
- ▶ ***John paid:* $1,000** (John's payment counts toward his plan's $2,000 deductible.)

Surgery

- *Hospital/surgery costs (without insurance):* $50,000
- *Anthem's negotiated rate:* $35,000
- ▶ ***John paid:* $1,000** (John's payment satisfies the remaining $1,000 deductible.)
- *Remaining cost of surgery:* $34,000

* While the characters in this example are not real, and the situation is hypothetical, the clinical aspects are accurate and realistic.

Coinsurance Once you've met your deductible, Anthem starts paying a portion of your claims. Then, you and Anthem share responsibility for your health care bills. Your coinsurance is the percentage that you must pay for a covered service each calendar year. Having met his deductible, John's coinsurance begins.	**Let's check in to see John's final costs:** • *Coinsurance:* .....30% (30% of $34,000 = $10,200) ▶ ***John paid:* $2,965** (John's payment satisfies the remainder of his $5,000 out-of-pocket limit.)
Out-of-pocket limit This is the most you pay during a calendar year. Your combined deductible, coinsurance and copay costs typically make up your out-of-pocket limit. Once you meet this limit, your health insurance covers 100% (of the maximum allowed amount) of covered services for the rest of the calendar year.	**John has met his out-of-pocket limit and the remaining surgery costs are paid by Anthem:** • *Anthem pays:* .....$31,035 • *Out-of-pocket limit:* $5,000
Summary John paid far less out of pocket because he had health care coverage and stayed in the network. If John had used a doctor outside our network, he would have paid more. Keep in mind that if your plan doesn't include coverage for out-of-network benefits, you'll pay the full cost for services from out-of-network providers with the exception of medically necessary emergency and urgent care.	• *Total for the doctor visit, MRI and surgery (without health insurance):* .....$51,700 • *Total Anthem paid after discounts:* .....$31,140 ▶ ***Total John paid:* .....$5,000** ($35 office visit + $2,000 deductible + $2,965 coinsurance = $5,000)

Call your Anthem Authorized Agent for more information.

You can also visit our website, **anthem.com/ca**, to view and compare different plans. To get started, choose **Shop for Insurance** in the top menu and follow the instructions.

* While the characters in this example are not real, and the situation is hypothetical, the clinical aspects are accurate and realistic.

Do you qualify for financial help?

With the Affordable Care Act (ACA), you have to get health care coverage unless you qualify for an exemption. But you may be eligible for financial help to pay for your insurance. This help would be in the form of tax credits toward your monthly premium on all plans or cost-sharing subsidies on Silver plans when you buy a plan on Covered California. The amount and type of financial aid you receive is based on your income, family size and where you live. **Minimum Coverage plans are not eligible for tax credits.**

How do you know if you qualify for a tax credit or cost-sharing subsidy?

If you purchase a plan on Covered California and your income is up to 400% of the federal poverty level, you may qualify for a tax credit that can be applied to the purchase of any level plan. Or, if your income is 250% of the federal poverty level and you're considering a Silver plan offered on Covered California, you may be able to get an additional cost-sharing subsidy.

- **Cost-sharing subsidies can make Silver plans ineligible for an HSA.** If you qualify for a cost-sharing subsidy, you may not be able to enroll in an HSA. Since cost-sharing subsidies lower your deductible and out-of-pocket costs, sometimes these amounts can drop below the federal government's minimum deductible threshold for HSA eligibility. If that happens, you would no longer qualify for the HSA feature and be automatically enrolled in the base plan without the HSA.

You may be eligible for financial help on your coverage.

To find out, go to coveredca.com. Scroll to the bottom of the page and click **Income Guidelines** under the Resources menu.

Avoid tax penalties

When you put off enrolling in a health plan, you may have to pay a penalty – unless you qualify for an exemption. Penalties are based on your income and increase each year for inflation. For example, the penalty for a family of four with a household income of $70,000 could be as much as $1,750 by 2016.

Overview of plans and network

Our network

What is a network?

When you need care, you'll get the best value by visiting contracted **in-network** doctors, hospitals or other health care providers. Anthem has negotiated discounted rates for covered services with these **in-network** providers to save you money. Since we can't control what **out-of-network** providers charge, if you choose to go outside of our network, you'll pay more out of pocket.

A network includes:

- Doctors, therapists, mental health providers and other health care professionals
- Hospitals and outpatient facilities
- Pharmacies
- ERs and urgent care centers
- Labs and radiology centers

Network details: Tiered PPO

Depending on what type of plan you choose, your benefits and provider choices may be different:

- **Tiered PPO:** With a PPO, you'll be able to see any provider you want without a referral because no primary care doctor gatekeepers are required. Also, PPOs provide coverage for both in-network and out-of-network providers — though you'll save when you stay in the network. This network includes tiered hospitals. Hospitals are split into two categories: Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1. Plans using tiered hospitals will have "Tiered" in the network name.

How do I know if a provider is in the network?

To check, use our ***Find a Doctor*** tool – it's quick and easy! Go to anthem.com/ca and select **Find a Doctor**. Then, select California and find the plan/network (Pathway X - PPO Tiered) you're considering. Choose what you're looking for (in-network doctors, specialists, hospitals or urgent care centers) and the location. You'll get a list of providers, including detailed information about them like location, gender, specialty, certifications, availability and much more. Network availability may depend on where you live.

For searches on the go, download our **anthem.com/ca** mobile app to your mobile device.

Reading our benefit charts

Take a look at the following charts to see explanations of some common benefits, such as deductibles, out-of-pocket limits and coinsurance amounts, for each plan level. **The benefit information shown is for *in-network* services only, unless otherwise noted.**

For more information, contact your Anthem Authorized Agent. You can also view and compare plans on anthem.com/ca. To get started, choose **Shop for Insurance** in the top menu and follow the instructions.

Here's a quick look at how to read our plan benefit charts.[1]

	Anthem Silver 70 PPO, a Multi-State Plan (a Tiered PPO Plan) (1X5T)
Network Name	Pathway X - PPO Tiered
Plan includes out-of-network coverage?	Yes
Individual Deductible *(In-network/ Out-of-network)*	$2,250 / $5,000
Individual Out-of-Pocket Limit *(In-network/ Out-of-network)*	$6,250 / $15,000
Coinsurance *(In-network/ Out-of-network)*	20% / 60% coinsurance
Office Visit: Primary Care Physician (PCP) *NOTE: Other office services may be subject to a deductible and plan coinsurance*	$45 copay, unlimited
Office Visit: Specialist	
Outpatient Diagnostic Tests	
Outpatient Advanced Diagnostic Tests	
Urgent Care	
Emergency Room Care	
Hospital: Inpatient Admission	
Hospital: Outpatient Facility	
Retail Pharmacy Deductible	
Retail Pharmacy Tier 1/Tier 2	
Retail Pharmacy Tier 3/Tier 4	
Dental and Vision	

- Indicates the plan name and contract code. Look for this when you're applying for a plan. The contract code is in parentheses after the plan name on the paper application.
- Indicates the plan's network. Use the ***Find a Doctor*** tool at anthem.com/ca to see if your doctor is in the network.
- Indicates whether the plan includes coverage for out-of-network benefits. **In-network** refers to providers who are part of the plan's network. **Out-of-network** refers to providers who don't participate in the network.
- The **deductible** is a set amount that you pay out of pocket before your plan starts paying for covered services, except for in-network preventive services.[2] ***For example:*** If your deductible is $2,250, your plan won't pay anything until you've met your $2,250 deductible for covered health care services. Some plans may cover certain services, such as doctor office visits, before you meet the deductible.

  Our plans have embedded family deductibles, where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, before receiving plan benefits. No one family member pays more than the individual deductible.

  The chart displays the individual deductible. Family deductibles are two (2) x the individual amount.

  Note: You must meet your deductible every calendar year (January 1 through December 31), even if your effective date (the date your coverage begins) is later than January 1.

[1] The cost-share amounts used in this example may not apply to the plan you're interested in. Be sure to look at the actual benefits for each plan when you're deciding.

[2] Nationally recommended preventive care services from in-network providers have no copay 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.

	Anthem Silver 70 PPO, a Multi-State Plan (a Tiered PPO Plan) (1X5T)
Network Name	Pathway X - PPO Tiered
Plan includes out-of-network coverage?	Yes
Individual Deductible *(in-network/ out-of-network)*	$2,250 / $5,000
Individual Out-of-Pocket Limit *(in-network/ out-of-network)*	$6,250 / $15,000
Coinsurance *(in-network/ out-of-network)*	20% / 60% coinsurance
Office Visit: Primary Care Physician (PCP) *NOTE: Other office services may be subject to a deductible and plan coinsurance*	$45 copay, unlimited
Office Visit: Specialist	
Outpatient Diagnostic Tests	
Outpatient Advanced Diagnostic Tests	
Urgent Care	
Emergency Room Care	
Hospital: Inpatient Admission	
Hospital: Outpatient Facility	
Retail Pharmacy Deductible	
Retail Pharmacy Tier 1/Tier 2	
Retail Pharmacy Tier 3/Tier 4	
Dental and Vision	

The **out-of-pocket limit** is the most you pay during a policy period (each calendar year) before your health insurance or plan begins to pay 100% of the maximum allowed amount. ***For example:*** If your out-of-pocket limit is $6,250, you'll continue to pay your coinsurance and copays, if applicable, until you've met your $6,250 out-of-pocket limit. Once you have met your out-of-pocket limit, your plan begins to pay 100% of the maximum allowed amount during that calendar year.

This limit never includes your premium or services your plan doesn't cover. The amount includes deductible, copays, coinsurance and pharmacy costs.

The chart displays the individual out-of-pocket limit. Family out-of-pocket limits are two (2) x the individual amount.

Coinsurance is the amount you pay for health care services. It's usually a certain percentage of the cost of services after the deductible has been paid. ***For example:*** A health plan pays 80% of the maximum allowed amount for a service and you pay the remaining 20% or coinsurance.

A **copay** is a fixed fee that you pay out of pocket for each visit to a health care provider. ***For example:*** If your copay is $45, then you pay $45 when you see your doctor — usually at the time you receive treatment. The amount of your copay may depend on the type of health care service you receive.

In-network preventive care is covered at no cost to you![2]

[1] The cost-share amounts used in this example may not apply to the plan you're interested in. Be sure to look at the actual benefits for each plan when you're deciding.

[2] Nationally recommended preventive care services from in-network providers have no copay 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.

Medical plans benefit charts

	Anthem Bronze 60 PPO (a Tiered PPO Plan) (1X5G)[8]	Anthem Bronze 60 Health Savings Account PPO (a Tiered PPO Plan) (1X5F)	Anthem Silver 70 PPO, a Multi-State Plan (a Tiered PPO Plan) (1X5T)[9,10]
Network Name[1]	Pathway X - PPO Tiered	Pathway X - PPO Tiered	Pathway X - PPO Tiered
Plan includes out-of-network coverage?	Yes	Yes	Yes
Individual Deductible[2,3] (In-network / Out-of-network)	$6,000 / $12,000	$4,500 / $9,000	$2,250 / $5,000
Individual Out-of-pocket Limit[2,3] (In-network / Out-of-network)	$6,500 / $18,000	$6,500 / $13,500	$6,250 / $15,000
Coinsurance[2] (In-network / Out-of-network)	NA / 60% coinsurance	40% / 60% coinsurance	20% / 60% coinsurance
Office Visit: Primary Care Physician (PCP)[4,5] NOTE: Other office services subject to deductible and plan coinsurance.	First 3 office visits: $70 copay, deductible waived 4+ office visits: Deductible, then $70 copay	Deductible, then 40% coinsurance	$45 copay, unlimited
Office Visit: Specialist[5]	First 3 office visits: $90 copay, deductible waived 4+ office visits: Deductible, then $90 copay	Deductible, then 40% coinsurance	$70 copay, unlimited
Outpatient Diagnostic Tests (Ex. X-ray, EKG)	Deductible, then 100% coinsurance	Deductible, then 40% coinsurance	$65 copay, not subject to deductible
Outpatient Advanced Diagnostic Tests (Ex. MRI, CT scan)	Deductible, then 100% coinsurance	Deductible, then 40% coinsurance	$250 copay, not subject to deductible
Preventive Care[6]	No additional cost	No additional cost	No additional cost
Urgent Care[5]	First 3 visits: $120 copay, deductible waived 4+ office visits: Deductible, then $120 copay	Deductible, then 40% coinsurance	$90 copay, not subject to deductible
Emergency Room Care (Copay is waived if admitted into the hospital from the Emergency Room)	Deductible, then 100% coinsurance	Deductible, then 40% coinsurance	Deductible, then $250 copay
Hospital: Inpatient Admission (includes maternity, mental health and substance abuse)	Deductible, then 100% coinsurance	Deductible, then 40% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance
Hospital: Outpatient Surgery Hospital Facility (includes maternity, mental health and substance abuse)	Deductible, then 100% coinsurance	Deductible, then 40% coinsurance	20% coinsurance, not subject to deductible
Retail Pharmacy Deductible[7] (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2, 3, 4: $500 Combined pharmacy deductible	Medical deductible applies	Tier 1: No deductible Tiers 2, 3, 4: $250 Combined pharmacy deductible
Retail Pharmacy Tier 1 / Tier 2	100% / 100% coinsurance up to $500 per script	40% / 40% coinsurance	$15 copay / $50 copay
Retail Pharmacy Tier 3 / Tier 4	100% / 100% coinsurance up to $500 per script	40% / 40% coinsurance	$70 copay / 20% coinsurance (tier 4, up to $250 per script)
Dental and Vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered

[1]Pathway X - PPO Tiered is a tiered network. In-network hospitals are split into two categories, Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1. Cost shares in the chart will show (tier 1) / (tier 2) coinsurance, if applicable.

[2]Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only.

[3]In-network and Out-of-network deductibles and In-network and Out-of-network out-of-pocket limits are separate and do not accumulate toward each other with the exception of medical emergency. In a medical emergency, cost shares apply toward the in-network deductible and the out-of-pocket limit.

[4]**LiveHealth Online** web visits have the same PCP office visit cost share listed in the chart.

[5]For plans with **PCP, Specialist** and **Urgent Care** office visit limits, the visit limits are combined, not separate.

[6]Nationally recommended **preventive care services** from in-network providers have no copay 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.

[7]For plans with a **Retail pharmacy deductible**, the pharmacy deductible is separate from the medical deductible. The family deductible is 2 x the individual amount.

[8]With this Bronze plan, you'll need to pay 100% of the cost for inpatient and outpatient services until you meet the plan's out-of-pocket limit. Once you meet the out-of-pocket limit, Anthem will pay 100%. You'll still end up paying less through our negotiated rates with these providers.

[9]You may qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on Covered California.

[10]Multi-State Plans are overseen by the U.S. Office of Personnel Management (OPM) and are similar to the other Qualified Health Plan products offered on the exchanges. The name "Multi-State Plan" does NOT mean that consumers have health plan coverage for non-urgent care in multiple states.

	Anthem Gold 80 PPO, a Multi-State Plan (a Tiered PPO Plan) (1X5M)[10]	Anthem Platinum 90 PPO (a Tiered PPO Plan) (1X5R)	Anthem Minimum Coverage PPO (a Tiered PPO Plan) (1X5P)
Network Name[1]	Pathway X - PPO Tiered	Pathway X - PPO Tiered	Pathway X - PPO Tiered
Plan includes out-of-network coverage?	Yes	Yes	Yes
Individual Deductible[2,3] (In-network / Out-of-network)	$0 / $5,000	$0 / $5,000	$6,850 / $13,700
Individual Out-of-pocket Limit[2,3] (In-network / Out-of-network)	$6,200 / $10,000	$4,000 / $10,000	$6,850 / $20,550
Coinsurance[2](In-network / Out-of-network)	20% / 60% coinsurance	10% / 60% coinsurance	0% / 60% coinsurance
Office Visit: Primary Care Physician (PCP)[4,5] NOTE: Other office services subject to deductible and plan coinsurance.	$35 copay, unlimited	$20 copay, unlimited	First 3 office visits: $0 copay, deductible waived 4+ office visits: Deductible, then 0% coinsurance
Office Visit: Specialist[5]	$55 copay, unlimited	$40 copay, unlimited	Deductible, then 0% coinsurance
Outpatient Diagnostic Tests (Ex. X-ray, EKG)	$50 copay	$40 copay	Deductible, then 0% coinsurance
Outpatient Advanced Diagnostic Tests (Ex. MRI, CT scan)	20% coinsurance	10% coinsurance	Deductible, then 0% coinsurance
Preventive Care[6]	No additional cost	No additional cost	No additional cost
Urgent Care[5]	$60 copay	$40 copay	First 3 office visits: $0 copay, deductible waived 4+ office visits: Deductible, then 0% coinsurance
Emergency Room Care (Copay is waived if admitted into the hospital from the Emergency Room)	$250 copay	$150 copay	Deductible, then 0% coinsurance
Hospital: Inpatient Admission (includes maternity, mental health and substance abuse)	20% (tier 1) / 50% (tier 2) coinsurance	10% (tier 1) / 40% (tier 2) coinsurance	Deductible, then 0% coinsurance
Hospital: Outpatient Surgery Hospital Facility (includes maternity, mental health and substance abuse)	20% coinsurance	10% coinsurance	Deductible, then 0% coinsurance
Retail Pharmacy Deductible[7] (for tiers with deductible, cost share applies after deductible)	No deductible	No deductible	Medical deductible applies
Retail Pharmacy Tier 1 / Tier 2	$15 / $50 copay	$5 / $15 copay	0% / 0% coinsurance
Retail Pharmacy Tier 3 / Tier 4	$70 copay / 20% coinsurance (tier 4, up to $250 per script)	$25 copay / 10% coinsurance (tier 4, up to $250 per script)	0% / 0% coinsurance
Dental and Vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered

[1]Pathway X - PPO Tiered is a tiered network. In-network hospitals are split into two categories, Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1. Cost shares in the chart will show (tier 1) / (tier 2) coinsurance, if applicable.

[2]Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only.

[3]In-network and Out-of-network deductibles and In-network and Out-of-network out-of-pocket limits are separate and do not accumulate toward each other with the exception of medical emergency. In a medical emergency, cost shares apply toward the in-network deductible and the out-of-pocket limit.

[4]**LiveHealth Online** web visits have the same PCP office visit cost share listed in the chart.

[5]For plans with **PCP, Specialist** and **Urgent Care** office visit limits, the visit limits are combined, not separate.

[6]Nationally recommended **preventive care services** from in-network providers have no copay 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.

[7]For plans with a **Retail pharmacy deductible**, the pharmacy deductible is separate from the medical deductible. The family deductible is 2 x the individual amount.

[8]With this Bronze plan, you'll need to pay 100% of the cost for inpatient and outpatient services until you meet the plan's out-of-pocket limit. Once you meet the out-of-pocket limit, Anthem will pay 100%. You'll still end up paying less through our negotiated rates with these providers.

[9]You may qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on Covered California.

[10]Multi-State Plans are overseen by the U.S. Office of Personnel Management (OPM) and are similar to the other Qualified Health Plan products offered on the exchanges. The name "Multi-State Plan" does NOT mean that consumers have health plan coverage for non-urgent care in multiple states.

Dental stand-alone plan benefit chart

	Anthem Family Dental PPO (1FQW) (Dependents age 18 and younger)	**Anthem Family Dental PPO (1FQW)** (Adults 19+)
	In-network / Out-of-network	**In-network / Out-of-network**
Dental Network	Dental Prime	Dental Prime
Deductible (per person, unless otherwise noted)	$65 per person /$130 per family[3]	$50 / $50[3]
Annual maximum[1] (per person)	None	$1,500 / $1,500
Annual out-of-pocket limit[2]	$350[4] / None	None
Diagnostic and Preventive	No waiting period	No waiting period
Cleaning, exams, x-rays	0% / 0% coinsurance	0% / 50% coinsurance
Extra cleaning	Not covered	Not covered
Basic services	No waiting period	No waiting period
Fillings	20% / 20% coinsurance	20% / 50% coinsurance
Brush biopsy	Not covered	Not covered
Complex & major services	No waiting period	6-month waiting period[5]
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50% / 50% coinsurance	50% / 50% coinsurance
Prosthetics (crowns, dentures, bridges)	50% / 50% coinsurance	50% / 50% coinsurance
Medically necessary orthodontia	50% / 50% coinsurance	Not covered
Cosmetic orthondontia	Not covered	Not covered
International emergency dental program	Included	Included

[1]Once the plan has paid the **Annual maximum** per person, the plan will not pay any more benefits for the rest of that calendar year.
[2]**Out-of-pocket limit** is the most you pay during a calendar year before your plan begins to pay 100% of the maximum allowed amount.
[3]Deductible is waived for **Diagnostic and Preventive** services received in our network.
[4]Per child, up to two children.
[5]The 6-month waiting period is waived with proof of prior dental coverage.

Our plans' built-in extras

At Anthem, we want to be more than your health benefits provider — we want to help you meet your day-to-day health and wellness goals. That's why we offer a variety of programs, discounts and tools to support you being your healthy best.

Health and wellness programs

From online health assessments and personal coaching to pregnancy and disease management support, we're here to give you the guidance you need, when you need it — at no extra cost. ***Here's how:***

- **24/7 Nurseline -** Day or night, you can talk to a registered nurse about your health concerns or ask specific questions about a condition you're managing (like asthma or diabetes) through our 24/7 NurseLine. Whether it's a question about allergies, the flu or choosing between the ER or urgent care, our nurses are always there for you.

- **ConditionCare -** Your health is our top priority. If you have an ongoing or complex health problem, a case manager may call you to see how we can help manage your condition and give you information and emotional support services.

And don't forget about those regular checkups! Your yearly exams, flu shots and other preventive care services are covered 100% with your health plan when you see a provider in the network. So you never have to think twice about calling your doctor and scheduling what you need.

SpecialOffers@Anthem℠

SpecialOffers@Anthem℠ (SpecialOffers) is our member discount program for health- and wellness-related products and services.

Through the program, members enjoy discounts on:

- Vitamins
- Health and beauty products
- Massage therapy
- LASIK eye surgery
- Eyeglass frames and contact lenses
- Hearing aids and services
- Jenny Craig® and Weight Watchers® weight-loss programs*
- Smoking cessation programs

To view all our SpecialOffers discounts, log in to anthem.com/ca and select **Discounts** on the ***Main Overview*** page.

*Weight Watchers and PointsPlus are the registered trademarks of Weight Watchers International, Inc. Trademarks used under license by WeightWatchers.com, Inc.

Enhanced Personal Health Care

Enhanced Personal Health Care is a new kind of doctor-patient relationship created just for Anthem PPO members!

We put members in a unique circle of care, making them the central focus of a team approach to their overall health. **Enhanced Personal Health Care** — a program that:

- Focuses on cost-saving strategies around chronic care and care management, engaging you in ways to manage your conditions for better health.
- Improves your patient experience with better access to a primary care doctor who cares for the "whole person" and becomes your health care champion and helps you navigate the health care system.
- Gives doctors added support with the right tools and strategies to help strengthen your doctor-patient relationship, so doctors can spend more time with you and coordinate your care with other doctors.

Together, you and your doctor work to make the best choices for your health care.

Travel coverage

With the Blue Cross and Blue Shield Association's BlueCard® program, you can access care no matter where you are in the U.S. or worldwide.

Whether you're traveling for work or on vacation, going to the ER or urgent care is probably the last thing you want to worry about. The good news is that our plans cover medically necessary emergency and urgent care in all 50 states.

Our Tiered PPO plans also include coverage for non-emergency care when you visit participating BlueCard providers in the U.S. or travel abroad. You can see any provider you wish, but you'll pay less out of pocket when you use BlueCard providers and hospitals.

Online tools

From our website and mobile app to cost and quality comparison tools, we want to make sure you have the information you need to make informed health care decisions for you and your family.

With our secure website, you can:

- Get a breakdown of what is and isn't covered by your plan through a benefit summary.
- See your recent claims and coverage details.
- Pay your premium online.
- Estimate your costs before having certain procedures.

With our mobile app, you can:

- Search for a nearby in-network doctor, specialist, urgent care center or hospital and get turn-by-turn directions to get there.
- Manage your prescription drug benefits, including pricing medications, switching from retail to home delivery and ordering refills.
- Carry a virtual member ID card.

Cost and quality information with Estimate Your Cost

With our Estimate Your Cost tool, you can save time and money by comparing the cost of common procedures at health care facilities in your area. You'll also get to see the quality and safety ratings for those facilities.

LiveHealth Online[1,2]

LiveHealth Online is a convenient way for you and your family to talk face-to-face with a board-certified doctor when your own doctor isn't available.[3] Just use your computer or mobile device to access medical care when you need it, 24/7.

No appointments, no driving and no waiting at an urgent care center. All you have to do is sign up at **livehealthonline.com** or download the app.

Once you become a member and register with LiveHealth Online, you can:

- Get medical advice, diagnoses, proper treatment and even prescriptions, as needed.[4]
- Quickly address common health problems, like allergies, colds, rashes, fever and more.
- See a doctor via video chat in minutes.

LiveHealth Online visits cost $49 or less depending on your health plan. It is currently available in English and Spanish.

[1] LiveHealth Online is the trade name of the Health Management Corporation.
[2] LiveHealth Online is only available with our PPO or Tiered PPO plans.
[3] LiveHealth Online is offered in most states and is expected to expand into more areas in the near future. Visit the home page at **livehealthonline.com** to see the latest map showing where service is available.
[4] This is legally permitted only in certain states.

Register at anthem.com/ca for online access.

Once you're a member, register at **anthem.com/ca** to access your benefits online. Choose **Register Now** on the top right-hand side of your screen.

Ready to enroll?

If you're ready to take the next step and enroll, we're here to help you every step of the way.

To get started, you'll need to have the following information handy:

- Employer and income details (for example, pay stubs and W-2 forms) for every member of your household who needs coverage
- Policy numbers and insurer names for any current health insurance plans covering members of your household
- Name of every job-based health insurance plan for which you or someone in your household is eligible

Then, you can:

- Call your Anthem Authorized Agent to enroll or learn more about our health care plans.
- Visit our website at anthem.com/ca and apply online.
- Find our plans on Covered California at coveredca.com.

Generally, plans can be purchased once a year through an open enrollment period. This year, the open enrollment period runs from November 1, 2015 through January 31, 2016. Be sure to enroll by December 15, 2015, to start coverage effective January 1, 2016.

The annual open enrollment period may vary from year to year, so you should check with your Anthem Authorized Agent for specific dates.

Your Anthem Authorized Agent is here to help you enroll. You can also apply online at anthem.com/ca.

We want you to be satisfied

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

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the *Agreement* may be continued in force or discontinued. For more complete details on what's covered and what isn't:

- Review the *Agreement*.
- Call your Anthem Authorized Agent.
- Go to anthem.com/ca.

To access a ***Summary of Benefits and Coverage*** (SBC), please visit www.sbc.anthem.com and select **Member**.

Anthem Blue Cross is a Qualified Health Plan issuer that offers individual health plans through Covered California.

In compliance with the ACA, the following plan changes may occur annually on January 1:

- Benefits
- Formularies
- Pharmacy and provider networks
- Premiums, copays and coinsurance

Still have questions?

Please reach out to your Anthem Authorized Agent. If you're stuck and unsure about next steps, we're here to listen and offer advice. We know there's a great plan out there just for you - let us help you find it!

Important plan information

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

Eligibility for a catastrophic plan

You are eligible for this plan if you:

- 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

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 and enrollees. 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. A subscriber's actual effective date is determined by the date he or she submits a complete application and the applicable premium to Covered California.

Special Enrollment

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

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

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 Management

Utilization management (UM) is a program that is part of your health plan. It lets us make sure you're getting the right care at the right time. Our UM 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 UM review team checks to make sure the treatment meets certain clinical guidelines set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The UM 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.

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

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

We may do a prospective review before a member goes to the hospital or has other types of services or treatment. Here are some types of medical treatments that might call for a prospective review:

- An inpatient hospital visit;
- An outpatient procedure;
- Tests to find the cause of an illness, like magnetic resonance imaging (MRI) and computed tomography (CT) scans;
- Certain types of outpatient therapy, like physical therapy or mental health counseling;
- Durable medical equipment (DME), like wheelchairs, walkers, crutches, hospital beds and more

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 in a doctor's office, regular office visits, physical therapy or mental health therapy, home health care, durable medical equipment, a stay in a nursing home, mental health care visits and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically necessary.

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

We do a retrospective review when you have already had surgery or another type of medical care. When the UM 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 managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Preauthorization

Preauthorization 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 preauthorization guidelines regularly. Preauthorization is also called "precertification," "prior authorization," or "pre-approval."

Here's how getting preauthorization can help you out:

Saving time. Preauthorizing services can save a step since you will know if you are eligible and what your benefits are before you get the service. The doctors in our network ask for preauthorization for our members.

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

What can you do? Choose a in-network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need preauthorization or call us to ask. The doctor's office will ask for preauthorization 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 see if you need preauthorization. Out-of-network providers may not do that for you. If

you ever have a question about whether you need preauthorization, just call the preauthorization or precertification phone number on your ID card.

Preferred Provider Organization (Tiered)

A Tiered Preferred Provider Organization (PPO) 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 certain 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.

There are two types of in-network hospitals – **preferred** in-network hospitals (tier 1) and in-network hospitals (tier 2). Your financial responsibility for covered services will be less when you visit and receive services from a preferred in-network (tier 1) hospital compared to an in-network (tier 2) hospital. Not all in-network providers (Ex. Doctors) can provide services at in-network (tier 2) hospitals. Contact us at **855-383-7247** or visit our **Find a Doctor** tool at anthem.com/ca for assistance locating **preferred** in-network (tier 1) hospitals, in-network (tier 2) hospitals or in-network providers (other than hospitals).

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 provide 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 physicians / providers (PCPs), specialists (specialty care physicians / providers (SCPs)), other professional providers, hospitals, and other facilities who contract with us to care for you. Referrals are never needed to visit an in-network specialist including behavioral health providers.

Laws and rights that protect you

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

Limitations

The specific limitations are spelled out in the terms of the particular plan, but some of the more common services limited by these plans are:

- Hearing aids – 1 pair per 36 months for members under age 18

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
- Care provided by a member of your family
- Care received in an emergency room that is not emergency care, except as specified in your Agreement
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Charges greater than the maximum allowable amount (charges exceeding the amount Anthem permits for services)
- Comfort and/or convenience items
- Cosmetic surgery
- Custodial care
- Health club memberships and fitness services
- Nutritional and dietary supplements, except as mandated
- Private duty nursing
- Services that aren't medically necessary
- Vision, except as described in your Agreement
- Workers' compensation

Medical Loss Ratio

Law requires us to tell you that Anthem Blue Cross' medical loss ratio (MLR) for 2014 was 80.3%. 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 plans are issued by Anthem Blue Cross : Anthem Bronze plans 60 PPO (a Tiered PPO Plan) and 60 Health Savings Account PPO (a Tiered PPO Plan); Anthem Silver 70 PPO, a Multi-State Plan (a Tiered PPO Plan); Anthem Gold 80 PPO, a Multi-State Plan (a Tiered PPO Plan); Anthem Platinum 90 PPO (a Tiered PPO Plan); and Anthem Minimum Coverage PPO (a Tiered PPO Plan).

Anthem does not discriminate based on race, color, ethnicity, national origin, religion, age, gender, gender identity, mental or physical disabilities, sexual orientation, genetic information, including pregnancy and expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition or health status in the administration of the plan, including enrollment, marketing practices, benefit designs, and benefit determinations.

SpecialOffers is a service mark of Anthem Insurance Companies, Inc. Vendors and offers are subject to change without notice. Anthem does not endorse and is not responsible for the products, services or information provided by the SpecialOffers vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members. All other marks are the property of their respective owners. All of the offers in the SpecialOffers program are continually being evaluated and expanded so the offerings may change. Any additions or changes will

be communicated on our website, anthem.com/ca. These arrangements have been made to add value for our members. Value-added products and services are not covered by your health plan benefit. Available discount percentages may change or be discontinued from time to time without notice. Discount is applicable to the items referenced.

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.

Notes

Get help today!

To learn more, call your Anthem Authorized Agent. You can also view and compare plans online at **anthem.com/ca**. To get started, choose **Shop for Insurance** in the top menu and follow the instructions.

If you'd like a paper copy of this information by fax or mail, contact your Anthem Authorized Agent.