2017 Plan Year: California Individual and Family

Your Health Plan Guide

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

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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 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 California-based provider network with access to major hospital systems.
- Dedicated customer service.
- All your benefits, including dental and vision, from one source.
- Competitive pricing.
- Convenient online tools, including 24/7 access to doctors through LiveHealth Online.
- A simple enrollment process.
- Resources to support your health care goals.

Anthem is right there with you.

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

- Local presence where you live and work
- A brand you can trust.

You want the best value your health care dollars can buy. And in California, that's our goal — through our commitment and our experience.

* Based on Internal Data, 2016.

Table of Contents

What we cover. 3
- Built in benefits. 3
- Pharmacy. 4

How to choose a plan. 5
- Networks. 6
- Travel coverage. 6
- What do you need?. 7
- Plan choices. 7
- Health savings account (HSA). 7
- How your plan might work. 8
- Qualify for financial help? 10

Overview of plans. 11
- Understanding insurance terms 11
- Medical plans 12
- Silver cost-share reduction (CSR) plans. 17
- Dental. 21
- Dental stand-alone plans. 22

Our plans' built-in extras. 24
- Health and wellness programs. 24
- SpecialOffers@Anthem℠. 24
- Enhanced Personal Health Care. 25

Online tools. 26
- LiveHealth Online. 26

Ready to enroll?. 27

We want you to be satisfied. 28

Important legal information. 29

Quick clicks

Get the info you want now. Just choose a topic to take you right to that section.

- Medical plans
- Networks
- Find a Doctor
- Prescriptions

What we cover

All our plan options have one major goal — to help you stay healthy and provide 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 plenty in between!

Built in 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 (going to the emergency room, also known as the ER) or urgent care center, when medically necessary
- Hospitalization and inpatient services (such as surgery)
- Laboratory and radiology services (includes blood work, screenings and X-rays)
- Mental health and substance use disorder services (includes counseling and psychotherapy)
- Pediatric dental and vision coverage for children up to age 19

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

With Anthem, you pay no copay, no coinsurance and no deductible for covered **in-network** preventive services. So you can stay on top of your health care and your finances!*

- Pregnancy, maternity and newborn care (care before, during and after pregnancy)
- Prescriptions
- Rehabilitative and habilitative services and devices (hospital beds, crutches, oxygen tanks)
- Visits to doctors in your plan for preventive care services* (wellness exams, shots, screenings) and chronic disease management

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

Pharmacy

Getting the most out of your pharmacy benefits can help keep you healthy and save you money. Here's what you need to know:

About our covered drug list

Anthem's pharmacy plans have a formulary/drug list, which is a list of covered prescription drugs that includes hundreds of brand name and generic medicines. Our individual and family plans use the Select Drug List, which offers drugs in every category and class that meet or exceed ACA requirements. The list tells you what tier your drug is in and provides guidance on how your cost shares are affected. Cost shares usually go up the higher the drug tier. Talk to your doctor about possible lower-cost options if your drug is in a higher tier.

Access all of your pharmacy information at anthem.com/ca

- Find out if your medication is covered. Check out our Select Drug List at anthem.com/ca/pharmacyinformation and click on the link, **Select Drug List (Searchable)**.
- See if your preferred pharmacy is in the plan's network. Visit anthem.com/ca/pharmacyinformation and select the **Rx Networks** tab.
- Learn more about using your pharmacy benefits, your drug list and get answers to questions about prior authorization and step therapy. See our list of FAQs located on the **Customer Support** tab.

Together with medical – better and easier than ever

With our combined pharmacy and medical programs, your doctor has a better picture of your health which can help result in:

- Better overall health
- A simplified experience
- Fewer hospital stays and reduced medical costs*
- Improved medication compliance
- Increased cost savings for prescriptions*

Save with prescription drug benefits

Anthem wants to help lower the cost of your prescription drugs, improve your overall health and deliver top-notch customer service. Here's how:

Save with Home Delivery Choice

We offer home delivery of your medicines right to your door. With the Home Delivery Choice program, you must choose how you want to get the medicines you take for ongoing conditions like indigestion, high blood pressure, high cholesterol or diabetes — at your local pharmacy or delivered to your doorstep.

We'll contact you by phone and mail to tell you about the program and its benefits. You can use a retail pharmacy for two fills, but after the second fill, your medicines will no longer be covered at your pharmacy until you make a final decision.

Using home delivery may help you save money. And it makes it easy for you to get your medicine quickly and safely.

Members can access Anthem's online pharmacy tools – anytime, anywhere

Manage everything you want and need to know about your prescription benefits in one place. It's easy. It's convenient. From getting your prescriptions filled to receiving health alert notifications and more, you can find it all by using our prescription benefit tools on anthem.com/ca. And many of the same helpful tools are available on your mobile device, so you can manage your drug benefit wherever you are.

* Outcomes based on 2014 integrated analysis. Results do not represent a guarantee of outcomes, group-specific results and cost savings will vary.
† Additional $10 copayment or 10% coinsurance may apply.

How to choose a plan

Networks...why choosing a doctor in your plan matters

One thing to think about when shopping for a health plan is your health plan's network of participating providers.

When Anthem sets up medical, dental and vision networks, we negotiate with doctors, hospitals and labs on the cost of services. For example, a doctor may normally charge $150 for an X-ray for a patient without medical benefits. We may negotiate with that same doctor to discount the rate for our Anthem members down to $100. Once this agreement is made, the doctor becomes part of our network of health care providers.

Bottom line: If you have a favorite doctor, hospital or other health care provider, you should always check to see if that provider is in our network, so you can get the benefit of the discounted or in-network rate.

Providers in your plan may include:

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

Our Find a Doctor tool — it's quick and easy

Go to **anthem.com/ca/findadoctor** and search using the plan/network (**Pathway X - PPO, Pathway X - HMO or Pathway X - EPO**) you're considering.

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 Anywhere** mobile app to your mobile device.

Network details: PPO, EPO and HMO

Depending on what type of plan you choose, your benefits and provider choices may be different. Plan offerings will also vary by county.

- **Preferred provider organization (PPO):** With a PPO, you'll be able to see any in-network provider. It's a good idea to have a primary care doctor to coordinate your care, so we'll select one close to your home and let you know your assignment in the beginning of the year. You don't need to see this doctor for services or referrals, and you can change your assigned primary care doctor at any time. Also, PPOs provide coverage for both in-network and out-of-network providers — though you'll save when you stay in the network.
- **Exclusive provider organization (EPO):** With our EPO plans, you'll be able to see any in-network provider. It's a good idea to have a primary care doctor to coordinate your care, so we'll select one close to your home and let you know your assignment in the beginning of the year. You don't need to see this doctor for services or referrals, and you can change your assigned primary care doctor at any time. EPO plans don't offer out-of-network benefits, except for emergency and urgent care or when a service is preapproved. If you go outside the network for any other reason, you'll have to pay 100% out of pocket.
- **Health maintenance organization (HMO):** With an HMO, you have to choose a primary care doctor to manage your care needs — including getting referrals to see other in-network doctors. HMOs don't offer out-of-network benefits, except for emergency and urgent care or when a service is preapproved. If you go outside the network for any other reason, you'll have to pay 100% out of pocket.

Travel coverage

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 you don't have to! With the Blue Cross and Blue Shield Association's BlueCard® program, you can access care no matter where you are in the United States (U.S.) or worldwide.

In the U.S. - All of our plans cover medically necessary emergency and urgent care in all 50 states. With our PPO and EPO plans, you can see any provider you wish, but you'll pay less out of pocket when you use BlueCard providers and hospitals.

Outside the U.S. – Our PPO and EPO plans also include coverage for medically necessary emergency care when you visit participating BlueCard providers while traveling abroad. BlueCard Worldwide® is a medical assistance program that connects our members traveling or living outside the United States, Puerto Rico and the U.S. Virgin Islands to a network of more than 9,000 hospitals and 21,000 health care professionals and outpatient care centers around the world.

Through the BlueCard Worldwide Service Center, members get claims support, referrals to providers, translation services and medical monitoring, 24/7. In addition, the BlueCard Worldwide Service Center may also provide medical evacuation coordination and other services, depending on the member's benefits and home plan.

The difference between doctors in the plan and doctors outside the plan

Doctors in the plan: Doctors and other health care providers who contract with us to provide care at discounted rates.

Doctors outside the plan: Doctors and other health care providers who are not contracted with the health plan.

If you choose to go to a doctor not in your plan, you'll pay more out of pocket.

What do you need?

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

What matters most to you?

Does the plan meet your coverage needs? How often do you see doctors and specialists? What prescription medications do you take regularly? Are you planning any procedures this year?

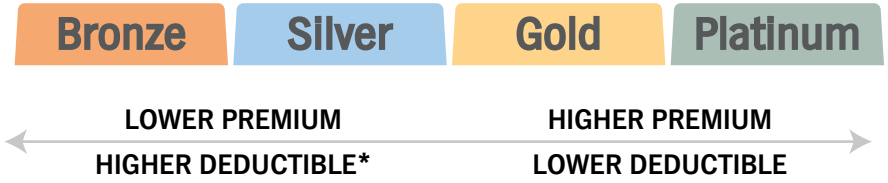
Do you have a certain doctor you like to see? If you answered yes, then you can use our Find a Doctor tool at **anthem.com/ca/findadoctor** to check if your doctor is in the plan you're considering.

Do you need to know if your medication is covered? Check out our drug list at **anthem.com/ca/pharmacyinformation** and click on the link, **Select Drug List (Searchable)**.

Is a Minimum Coverage (also known as Catastrophic) plan an option? If you're under age 30 or are 30 or older with an approved hardship exemption from Covered California (your state's Marketplace) you may qualify for a high deductible, low monthly payment, Minimum Coverage plan. Minimum coverage plans can help protect you from worst-case scenarios like serious accidents or illnesses.

Plan choices

Metal Levels



Health savings account (HSA)

If you like the idea of lowering your health care costs and your taxes, a health savings account (HSA) could be a good option for you.

- **What is it?**
  It's a savings account you can open when you have a qualified high-deductible health plan (HDHP). You set up the HSA through a bank and fund it with your post tax dollars.
- **Why choose it?**
  It can help you pay for health care expenses, including prescriptions. Plus, you can claim your HSA contributions as tax deductions, earn interest on your money and roll over the year-end balance.
- **How can you learn more?**
  Check with your tax advisor to see if an HSA plan is right for you. Plans with 'HDHP' in the name are compatible with an HSA. For more information on HSAs, review our HSA flier included with this brochure.

* 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 covered services you receive with your health insurance company. **With Anthem, you choose the level of cost sharing that works for you.**

Here's an example: *Meet Jason**

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

Jason's story

After injuring his knee in a soccer game, Jason chooses a doctor in our network, which saves him the most money. Jason pays a copay or coinsurance based on Anthem negotiated rates because he uses doctors in our network. **Below, see how Jason's benefits work, his treatment costs and why it's important to have health insurance:***

Jason's health plan has the following benefits:

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

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 primary care doctor 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.

Examples of covered services that apply to the deductible include lab work, X-rays, anesthesia and surgeon fees.

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

- *Doctor visit cost (without insurance):* $200
- *Anthem's negotiated rate:* $140
- *Anthem pays:* $105
- ***Jason paid:*** **$35**

(This is his plan's copay for primary care doctor office visits.)

Here's what happens when Jason'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
- ***Jason paid:*** **$1,000**

(Jason's payment counts toward his plan's $2,000 deductible.)

Surgery

- *Hospital/surgery costs (without insurance):* $50,000
- *Anthem's negotiated rate:* $35,000
- ***Jason paid:*** **$1,000**

(Jason'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 (your percentage of the cost)

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 certain covered services. Having met his deductible, Jason begins to pay coinsurance on covered services that require it.

Let's check in to see Jason's final costs for surgery:

- *Coinsurance* (30% of $34,000): $10,200
- ***Jason paid:*** **$2,965**

(Jason's payment satisfies the remainder of his $5,000 out-of-pocket limit. Even though Jason's coinsurance is 30% or $10,200, he only has to pay a portion of that to meet his $5,000 out-of-pocket limit.)

Out-of-pocket limit

This is the most you pay during a calendar year for covered services. 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.

Jason has met his in-network out-of-pocket limit and the remaining surgery costs are paid by Anthem:

- *Anthem pays:* $31,035
- *Jason's out-of-pocket limit:* $5,000

Summary

Jason paid far less out of pocket because he had health care coverage and stayed in our network. If Jason had used a doctor outside our network, he would have paid more.

Keep in mind if your plan doesn't include coverage for out-of-network benefits, you'll pay the full cost for services from doctors not in our network with the exception of medically necessary emergency and urgent care.

Let's check in to see Jason's final costs:

- *Total for the doctor visit, MRI and surgery (without health insurance):* $51,700
- *Total Anthem paid after discounts:* $31,140
- ***Total Jason 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 **anthem.com/ca** or **coveredca.com** to view and compare different plans.

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

Qualify for financial help?

With the Affordable Care Act (ACA), most people have to get health care coverage unless they qualify for an exemption. But you may be eligible for financial help to pay for your insurance.

Your medical plan may not cost as much as you think

Depending on your income and family size, you may qualify for an advance premium tax credit (APTC) on any metal level plan, excluding Minimum Coverage plans, when you buy a plan through Covered California. If you qualify, you may be able to enroll in certain Silver plans available on Covered California that offer a reduction in the deductible, copays and out-of-pocket costs charged under that plan. This is called a cost-share reduction (CSR) plan (also called cost-sharing subsidy). These options are shown in the chart below as 73% Silver CSR, 87% Silver CSR and 94% Silver CSR.

Use the chart below to see if you qualify for a cost-share reduction.

1. Find your family size. Then, figure out your yearly income and move across the row to find the income range that applies to your household.

2. Look at the percentage at the top of the chart to see where you fall on the Federal Poverty Level (FPL).

3. Go to the second row to find the plan you qualify for.* Then, check out our Silver cost-share reduction plans for details.

2017 Federal Poverty Level

	Less than 138%		138% - 150%	151% - 200%	201% - 250%
You qualify for	Medicaid Eligible		94% Silver CSR	87% Silver CSR	73% Silver CSR
Family Size					
1	$11,880	$16,394	$16,395-$17,820	$17,821-$23,760	$23,761-$29,700
2	$16,020	$22,108	$22,109-$24,030	$24,031-$32,040	$32,041-$40,050
3	$20,160	$27,821	$27,822-$30,240	$30,241-$40,320	$40,321-$50,400
4	$24,300	$33,534	$33,535-$36,450	$36,451-$48,600	$48,601-$60,750
5	$28,440	$39,247	$39,248-$42,660	$42,661-$56,880	$56,881-$71,100
6	$32,580	$44,960	$44,961-$48,870	$48,871-$65,160	$65,161-$81,450
7	$36,730	$50,687	$50,688-$55,095	$55,096-$73,460	$73,461-$91,825
8	$40,890	$56,428	$56,429-$61,335	$61,336-$81,780	$81,781-$102,225

Source: Calculations based on data from the U.S. Department of Health and Human Services, www.federalregister.gov/documents/2016/01/25/2016-01450/annual-update-of-the-hhs-poverty-guidelines.
* Other metal level plans are available, but are not eligible for a cost-share reduction.

Avoid tax penalties

If you don't enroll in a medical 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. To learn how tax penalties could affect you, contact a tax advisor.

Cost-sharing subsidies can make Silver plans ineligible for an HSA.

If you qualify for a CSR plan, 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 drop below the federal government's minimum deductible threshold for HSA eligibility. If this is the case, you won't qualify for the HSA feature. You'll then be automatically enrolled in the base plan without the HSA.

What does it mean to shop on or off the Marketplace?

The medical plans you see in this brochure are only available on Covered California (your state's Marketplace). If you don't qualify for an APTC or a Silver CSR plan, you may want to shop off the Marketplace at **anthem.com/ca**. We have lots of plans to choose from, and we can help you find one just right for you.

Does the chart show you qualify for a Silver CSR plan? Then, you'll need to shop on Covered California. You can still buy an Anthem plan at **coveredca.com**, where you can take advantage of an APTC or Silver CSR plan, if you qualify.

Whether you shop on or off the Marketplace, you can compare plans and get a quote on the plan that fits your needs. Contact your Anthem Authorized Agent and ask about our plans.

Overview of plans

Understanding insurance terms

In-network preventive care is covered at no additional cost to you!*

Insurance terms can be confusing. Here's a quick look at some commonly used health insurance terms.

Take a look at the following pages to see the individual and family medical plan choices offered by Anthem, including a sample of commonly used benefits and how they're covered under each plan. **Cost-share and benefit information shown is for *in-network* services only.**

For more information, contact your Anthem Authorized Agent. You can also view and compare plans on anthem.com/ca.

Plan name	Plan name and contract code are found in the first row of the medical plan charts. Look for this when you're applying for a plan. The contract code is in parentheses after the plan name on the paper application.
Plan includes out-of-network coverage?	Indicates whether the plan includes coverage for out-of-network benefits. **In-network** refers to doctors who are part of the plan's network. **Out-of-network** refers to doctors who don't participate in the network.
Deductible	The **deductible** is a set amount that you pay out of pocket each year before your plan starts paying for covered services, except for in-network preventive services.* *For example:* If your deductible is $5,000, your plan won't pay anything until you've met your $5,000 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 medical plan charts display the individual deductible. Family deductibles are two (2) times 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.
Out-of-pocket limit	The **out-of-pocket** limit is the most you pay during a policy period (each calendar year) before your health insurance or plan pays 100% of the maximum allowed amount. *For example:* If your out-of-pocket limit is $6,850, you will continue to pay your coinsurance and copays, if applicable, until you've met your $6,850 out-of-pocket limit. Once you have met your out-of-pocket limit, your plan pays 100% of the maximum allowed amount for covered services for the rest of that calendar year. This limit never includes your monthly payment (premium) or services your plan doesn't cover. The amount includes deductible, copays, coinsurance and pharmacy costs. The medical plan charts display the individual out-of-pocket limit. Family out-of-pocket limits are two (2) times the individual amount.
Coinsurance	**Your percentage of the cost (Coinsurance)** is the amount you pay for covered health care services. It's a 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%. All medical plans have coinsurance, but the percentage may vary by health care service.
Copay	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 $50, then you pay $50 when you see your in-network doctor — usually at the time you receive treatment. The amount of your copay may depend on the type of health care service you receive.

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

Medical plans - PPO

PPO plans include out-of-network benefits. 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. PPO plans are available in Fresno, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Merced, Mono, San Joaquin, San Luis Obispo, Santa Barbara, Stanislaus, Tulare and Ventura counties.

	Anthem Bronze 60 HDHP PPO (2KUH)	**Anthem Bronze 60 PPO (2KUC)**	**Anthem Silver 70 PPO, an MSP (2KUE)**
Network name	Pathway X - PPO	Pathway X - PPO	Pathway X - PPO
Plan includes out-of-network coverage?	Yes	Yes	Yes
Individual deductible[1]	$4,800 / $9,000 In-network / Out-of-network	$6,300 / $12,000 In-network / Out-of-network	$2,500 / $5,000 In-network / Out-of-network
Individual out-of-pocket limit[1]	$6,550 / $13,500 In-network / Out-of-network	$6,800 / $18,000 In-network / Out-of-network	$6,800 / $15,000 In-network / Out-of-network
Coinsurance (percentage may vary for some covered services)	40% / 60% In-network / Out-of-network	100% / 50% In-network / Out-of-network	20% / 50% In-network / Out-of-network
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[3,4] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 40% coinsurance	$75 copay per visit for the first 3 visits, then deductible and $75 copay	$35 copay, deductible waived
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 40% coinsurance	$105 copay per visit for the first 3 visits, then deductible and $105 copay	$70 copay, deductible waived
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 40% coinsurance	Deductible, then 100% coinsurance until out-of-pocket limit is met	$70 copay, deductible waived
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 40% coinsurance	Deductible, then 100% coinsurance until out-of-pocket limit is met	$300 copay, deductible waived
Urgent care[4]	Deductible, then 40% coinsurance	$75 copay per visit for the first 3 visits, then deductible and $75 copay	$35 copay, deductible waived
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 40% coinsurance	Deductible, then 100% coinsurance until out-of-pocket limit is met	$350 copay, deductible waived
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 40% coinsurance	Deductible, then 100% coinsurance until out-of-pocket limit is met	Deductible, then 20% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 40% coinsurance	Deductible, then 100% coinsurance until out-of-pocket limit is met	20% coinsurance, deductible waived
Pharmacy deductible[5] (for tiers with deductible, cost share applies after deductible)	Tier 1, 2, 3, 4: Medical deductible applies	Tier 1, 2, 3, 4: $500 Combined pharmacy deductible	Tier 1: No deductible Tier 2, 3, 4: $250 Combined pharmacy deductible
Retail pharmacy tier 1	40% coinsurance (up to $500 per script)	100% coinsurance (up to $500 per script)	$15 copay
Retail pharmacy tier 2	40% coinsurance (up to $500 per script)	100% coinsurance (up to $500 per script)	$55 copay
Retail pharmacy tier 3	40% coinsurance (up to $500 per script)	100% coinsurance (up to $500 per script)	$80 copay
Retail pharmacy tier 4	40% coinsurance (up to $500 per script)	100% coinsurance (up to $500 per script)	20% coinsurance (up to $250 per script)
Physical and occupational therapy	Deductible, then 40% coinsurance	$75 copay, deductible waived	$35 copay, deductible waived
Speech therapy	Deductible, then 40% coinsurance	$75 copay, deductible waived	$35 copay, deductible waived

Please see Medical and Silver cost-share reduction plans footnotes on page 20.

Medical plans - PPO

PPO plans include out-of-network benefits. 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. PPO plans are available in Fresno, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Merced, Mono, San Joaquin, San Luis Obispo, Santa Barbara, Stanislaus, Tulare and Ventura counties.

	Anthem Gold 80 PPO, an MSP (2KUP)	**Anthem Platinum 90 PPO (2KUR)**	**Anthem Minimum Coverage PPO (2KUF)**
Network name	Pathway X - PPO	Pathway X - PPO	Pathway X - PPO
Plan includes out-of-network coverage?	Yes	Yes	Yes
Individual deductible[1]	$0 / $5,000 In-network / Out-of-network	$0 / $5,000 In-network / Out-of-network	$7,150 / $13,700 In-network / Out-of-network
Individual out-of-pocket limit[1]	$6,750 / $10,000 In-network / Out-of-network	$4,000 / $10,000 In-network / Out-of-network	$7,150 / $20,550 In-network / Out-of-network
Coinsurance (percentage may vary for some covered services)	20% / 50% In-network / Out-of-network	10% / 40% In-network / Out-of-network	0% / 30% In-network / Out-of-network
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[3,4] (Other office services may be subject to deductible and plan coinsurance)	$30 copay	$15 copay	0% coinsurance per visit for the first 3 visits, then deductible and 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	$55 copay	$40 copay	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	$55 copay	$40 copay	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	20% coinsurance	10% coinsurance	Deductible, then 0% coinsurance
Urgent care[4]	$30 copay	$15 copay	0% coinsurance per visit for the first 3 visits, then deductible and 0% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	$325 copay	$150 copay	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	20% coinsurance	10% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	20% coinsurance	10% coinsurance	Deductible, then 0% coinsurance
Pharmacy deductible[5] (for tiers with deductible, cost share applies after deductible)	Tier 1, 2, 3, 4: No deductible	Tier 1, 2, 3, 4: No deductible	Tier 1, 2, 3, 4: Medical deductible applies
Retail Pharmacy tier 1	$15 copay	$5 copay	0% coinsurance
Retail pharmacy tier 2	$55 copay	$15 copay	0% coinsurance
Retail pharmacy tier 3	$75 copay	$25 copay	0% coinsurance
Retail pharmacy tier 4	20% coinsurance (up to $250 per script)	10% coinsurance (up to $250 per script)	0% coinsurance
Physical and occupational therapy	$30 copay	$15 copay	Deductible, then 0% coinsurance
Speech therapy	$30 copay	$15 copay	Deductible, then 0% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 20.

Medical plans - EPO

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

EPO plans are available Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costra, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Los Angeles (North), Los Angeles (South), Marin, Mendocino, Modoc, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo and Yuba counties.

	Anthem Bronze 60 HDHP EPO (2EUX)	**Anthem Bronze 60 EPO (2EUU)**	**Anthem Silver 70 EPO, an MSP (2EV6)**
Network name	Pathway X – EPO	Pathway X – EPO	Pathway X – EPO
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$4,800	$6,300	$2,500
Individual out-of-pocket limit[1]	$6,550	$6,800	$6,800
Coinsurance (percentage may vary for some covered services)	40%	100%	20%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[3,4] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 40% coinsurance	$75 copay per visit for the first 3 visits, then deductible and $75 copay	$35 copay, deductible waived
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 40% coinsurance	$105 copay per visit for the first 3 visits, then deductible and $105 copay	$70 copay, deductible waived
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 40% coinsurance	Deductible, then 100% coinsurance until out-of-pocket limit is met	$70 copay, deductible waived
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 40% coinsurance	Deductible, then 100% coinsurance until out-of-pocket limit is met	$300 copay, deductible waived
Urgent care[4]	Deductible, then 40% coinsurance	$75 copay per visit for the first 3 visits, then deductible and $75 copay	$35 copay, deductible waived
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 40% coinsurance	Deductible, then 100% coinsurance until out-of-pocket limit is met	$350 copay, deductible waived
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 40% coinsurance	Deductible, then 100% coinsurance until out-of-pocket limit is met	Deductible, then 20% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 40% coinsurance	Deductible, then 100% coinsurance until out-of-pocket limit is met	20% coinsurance, deductible waived
Pharmacy deductible[5] (for tiers with deductible, cost share applies after deductible)	Tier 1, 2, 3, 4: Medical deductible applies	Tier 1, 2, 3, 4: $500 Combined pharmacy deductible	Tier 1: No deductible Tier 2, 3, 4: $250 Combined pharmacy deductible
Retail pharmacy tier 1	40% coinsurance (up to $500 per script)	100% coinsurance (up to $500 per script)	$15 copay
Retail pharmacy tier 2	40% coinsurance (up to $500 per script)	100% coinsurance (up to $500 per script)	$55 copay
Retail pharmacy tier 3	40% coinsurance (up to $500 per script)	100% coinsurance (up to $500 per script)	$80 copay
Retail pharmacy tier 4	40% coinsurance (up to $500 per script)	100% coinsurance (up to $500 per script)	20% coinsurance (up to $250 per script)
Physical and occupational therapy	Deductible, then 40% coinsurance	$75 copay, deductible waived	$35 copay, deductible waived
Speech therapy	Deductible, then 40% coinsurance	$75 copay, deductible waived	$35 copay, deductible waived

Please see Medical and Silver cost-share reduction plans footnotes on page 20.

Medical plans - EPO

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

EPO plans are available Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costra, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Los Angeles (North), Los Angeles (South), Marin, Mendocino, Modoc, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo and Yuba counties.

	Anthem Gold 80 EPO, an MSP (2EVB)	**Anthem Platinum 90 EPO (2EUR)**	**Anthem Minimum Coverage EPO (2EUN)**
Network name	Pathway X – EPO	Pathway X – EPO	Pathway X – EPO
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$0	$0	$7,150
Individual out-of-pocket limit[1]	$6,750	$4,000	$7,150
Coinsurance (percentage may vary for some covered services)	20%	10%	0%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[3,4] (Other office services may be subject to deductible and plan coinsurance)	$30 copay	$15 copay	0% coinsurance per visit for the first 3 visits, then deductible and 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	$55 copay	$40 copay	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	$55 copay	$40 copay	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	20% coinsurance	10% coinsurance	Deductible, then 0% coinsurance
Urgent care[4]	$30 copay	$15 copay	0% coinsurance per visit for the first 3 visits, then deductible and 0% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	$325 copay	$150 copay	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	20% coinsurance	10% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	20% coinsurance	10% coinsurance	Deductible, then 0% coinsurance
Pharmacy deductible[5] (for tiers with deductible, cost share applies after deductible)	Tier 1, 2, 3, 4: No deductible	Tier 1, 2, 3, 4: No deductible	Tier 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1	$15 copay	$5 copay	0% coinsurance
Retail pharmacy tier 2	$55 copay	$15 copay	0% coinsurance
Retail pharmacy tier 3	$75 copay	$25 copay	0% coinsurance
Retail pharmacy tier 4	20% coinsurance (up to $250 per script)	10% coinsurance (up to $250 per script)	0% coinsurance
Physical and occupational therapy	$30 copay	$15 copay	Deductible, then 0% coinsurance
Speech therapy	$30 copay	$15 copay	Deductible, then 0% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 20.

Medical plans - HMO

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

HMO plans are available in El Dorado, Fresno, Los Angeles (North), Los Angeles (South), Kings, Madera, Orange, Placer, Riverside, Sacramento, San Bernardino, Santa Clara, San Diego and Yolo counties. Important: HMO plans are not available in all zip codes within some counties. Please see the list of excluded zip codes under **Important legal information.**

	Anthem Silver 70 HMO (1G01)	**Anthem Gold 80 HMO (1G0A)**	**Anthem Platinum 90 HMO (1G0G)**
Network name	Pathway X - HMO	Pathway X - HMO	Pathway X - HMO
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$2,500	$0	$0
Individual out-of-pocket limit[1]	$6,800	$6,750	$4,000
Coinsurance (percentage may vary for some covered services)	20%	20%	10%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[3,4] (Other office services may be subject to deductible and plan coinsurance)	$35 copay, deductible waived	$30 copay	$15 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	$70 copay, deductible waived	$55 copay	$40 copay
Outpatient diagnostic tests (Ex. X-ray, EKG)	$70 copay, deductible waived	$55 copay	$40 copay
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	$300 copay, deductible waived	$275 copay	$150 copay
Urgent care[4]	$35 copay, deductible waived	$30 copay	$15 copay
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	$350 copay, deductible waived	$325 copay	$150 copay
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 20% coinsurance	$600 copay per day up to 5 days	$250 copay per day up to 5 days
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	20% coinsurance, deductible waived	$600 copay	$250 copay
Pharmacy deductible[5] (for tiers with deductible, cost share applies after deductible)	Tier 1: No deductible Tier 2, 3, 4: $250 Combined pharmacy deductible	Tier 1, 2, 3, 4: No deductible	Tier 1, 2, 3, 4: No deductible
Retail pharmacy tier 1	$15 copay	$15 copay	$5 copay
Retail pharmacy tier 2	$55 copay	$55 copay	$15 copay
Retail pharmacy tier 3	$80 copay	$75 copay	$25 copay
Retail pharmacy tier 4	20% coinsurance (up to $250 per script)	20% coinsurance (up to $250 per script)	10% coinsurance (up to $250 per script)
Physical and occupational therapy	$35 copay, deductible waived	$30 copay	$15 copay
Speech therapy	$35 copay, deductible waived	$30 copay	$15 copay

Please see Medical and Silver cost-share reduction plans footnotes on page 20.

Silver cost-share reduction (CSR) plans - PPO

These plans are available if you qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on Covered California. Have questions? Call your Anthem Authorized Agent.

	Anthem Silver 73 PPO, an MSP (2KUN)	Anthem Silver 87 PPO, an MSP (2KUM)	Anthem Silver 94 PPO, an MSP (2KUL)
Network name	Pathway X - PPO	Pathway X - PPO	Pathway X - PPO
Plan includes out-of-network coverage?	Yes	Yes	Yes
Individual deductible[1]	$2,200 / $5,000 In-network / Out-of-network	$650 / $5,000 In-network / Out-of-network	$75 / $5,000 In-network / Out-of-network
Individual out-of-pocket limit[1]	$5,700 / $15,000 In-network / Out-of-network	$2,350 / $15,000 In-network / Out-of-network	$2,350 / $15,000 In-network / Out-of-network
Coinsurance (percentage may vary for some covered services)	20% / 50% In-network / Out-of-network	15% / 50% In-network / Out-of-network	10% / 50% In-network / Out-of-network
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[3,4] (Other office services may be subject to deductible and plan coinsurance)	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	$55 copay, deductible waived	$25 copay, deductible waived	$8 copay, deductible waived
Outpatient diagnostic tests (Ex. X-ray, EKG)	$65 copay, deductible waived	$25 copay, deductible waived	$8 copay, deductible waived
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	$300 copay, deductible waived	$100 copay, deductible waived	$50 copay, deductible waived
Urgent care[4]	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	$350 copay, deductible waived	$100 copay, deductible waived	$50 copay, deductible waived
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 10% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	20% coinsurance, deductible waived	15% coinsurance, deductible waived	10% coinsurance, deductible waived
Pharmacy deductible[5] (for tiers with deductible, cost share applies after deductible)	Tier 1: No deductible Tier 2, 3, 4: $250 Combined pharmacy deductible	Tier 1: No deductible Tier 2, 3, 4: $50 Combined pharmacy deductible	Tier 1, 2, 3, 4: No deductible
Retail pharmacy tier 1	$15 copay	$5 copay	$3 copay
Retail pharmacy tier 2	$50 copay	$20 copay	$10 copay
Retail pharmacy tier 3	$75 copay	$35 copay	$15 copay
Retail pharmacy tier 4	20% coinsurance (up to $250 per script)	15% coinsurance (up to $150 per script)	10% coinsurance (up to $150 per script)
Physical and occupational therapy	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived
Speech therapy	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived

Please see Medical and Silver cost-share reduction plans footnotes on page 20.

Silver cost-share reduction (CSR) plans - EPO

These plans are available if you qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on Covered California. Have questions? Call your Anthem Authorized Agent.

	Anthem Silver 73 EPO, an MSP (2EV7)	Anthem Silver 87 EPO, an MSP (2EV8)	Anthem Silver 94 EPO, an MSP (2EV9)
Network name	Pathway X – EPO	Pathway X – EPO	Pathway X – EPO
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$2,200	$650	$75
Individual out-of-pocket limit[1]	$5,700	$2,350	$2,350
Coinsurance (percentage may vary for some covered services)	20%	15%	10%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[3,4] (Other office services may be subject to deductible and plan coinsurance)	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	$55 copay, deductible waived	$25 copay, deductible waived	$8 copay, deductible waived
Outpatient diagnostic tests (Ex. X-ray, EKG)	$65 copay, deductible waived	$25 copay, deductible waived	$8 copay, deductible waived
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	$300 copay, deductible waived	$100 copay, deductible waived	$50 copay, deductible waived
Urgent care[4]	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	$350 copay, deductible waived	$100 copay, deductible waived	$50 copay, deductible waived
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 10% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	20% coinsurance, deductible waived	15% coinsurance, deductible waived	10% coinsurance, deductible waived
Pharmacy deductible[5] (for tiers with deductible, cost share applies after deductible)	Tier 1: No deductible Tier 2, 3, 4: $250 Combined pharmacy deductible	Tier 1: No deductible Tier 2, 3, 4: $50 Combined pharmacy deductible	Tier 1, 2, 3, 4: No deductible
Retail pharmacy tier 1	$15 copay	$5 copay	$3 copay
Retail pharmacy tier 2	$50 copay	$20 copay	$10 copay
Retail pharmacy tier 3	$75 copay	$35 copay	$15 copay
Retail pharmacy tier 4	20% coinsurance (up to $250 per script)	15% coinsurance (up to $150 per script)	10% coinsurance (up to $150 per script)
Physical and occupational therapy	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived
Speech therapy	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived

Please see Medical and Silver cost-share reduction plans footnotes on page 20.

Silver cost-share reduction (CSR) plans - HMO

These plans are available if you qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on Covered California. Have questions? Call your Anthem Authorized Agent.

	Anthem Silver 73 HMO (1G05)	Anthem Silver 87 HMO (1G04)	Anthem Silver 94 HMO (1G03)
Network name	Pathway X - HMO	Pathway X - HMO	Pathway X - HMO
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$2,200	$650	$75
Individual out-of-pocket limit[1]	$5,700	$2,350	$2,350
Coinsurance (percentage may vary for some covered services)	20%	15%	10%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[3,4] (Other office services may be subject to deductible and plan coinsurance)	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	$55 copay, deductible waived	$25 copay, deductible waived	$8 copay, deductible waived
Outpatient diagnostic tests (Ex. X-ray, EKG)	$65 copay, deductible waived	$25 copay, deductible waived	$8 copay, deductible waived
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	$300 copay, deductible waived	$100 copay, deductible waived	$50 copay, deductible waived
Urgent care[4]	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	$350 copay, deductible waived	$100 copay, deductible waived	$50 copay, deductible waived
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 10% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	20% coinsurance, deductible waived	15% coinsurance, deductible waived	10% coinsurance, deductible waived
Pharmacy deductible[5] (for tiers with deductible, cost share applies after deductible)	Tier 1: No deductible Tier 2, 3, 4: $250 Combined pharmacy deductible	Tier 1: No deductible Tier 2, 3, 4: $50 Combined pharmacy deductible	Tier 1, 2, 3, 4: No deductible
Retail pharmacy tier 1	$15 copay	$5 copay	$3 copay
Retail pharmacy tier 2	$50 copay	$20 copay	$10 copay
Retail pharmacy tier 3	$75 copay	$35 copay	$15 copay
Retail pharmacy tier 4	20% coinsurance (up to $250 per script)	15% coinsurance (up to $150 per script)	10% coinsurance (up to $150 per script)
Physical and occupational therapy	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived
Speech therapy	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived

Please see Medical and Silver cost-share reduction plans footnotes on page 20.

Medical and Silver cost-share reduction plans benefit footnotes

1 In-network and Out-of-network deductibles and In-network and Out-of-network out-of-pocket limits are separate and don't 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.
2 Nationally recommended **preventive care services** from in-network providers have no copay, no coinsurance and no deductible requirement. Preventive and wellness services consist of certain services, including well-child care, immunizations, prostate-specific antigen (PSA) screenings, Pap tests, mammograms and more, recommended by the United States Preventive Services Task Force.
3 **LiveHealth Online** web visits have the same PCP office visit cost share listed in the chart.
4 For plans with **PCP, Specialist** and **Urgent Care** office visit limits, the visit limits are combined, not separate.
5 For plans with a **Retail pharmacy deductible**, the pharmacy deductible is separate from the medical deductible. The family deductible is 2 times the individual amount.

It's important to know that with our Anthem Bronze 60 PPO (2KUC) and Anthem Bronze 60 EPO (2EUU) plans, 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% of the maximum allowed amount for covered services for the rest of that calendar year. You'll still end up paying less through our negotiated rates with these providers.

NOTE: Multi-State Plans (also known as MSP) are overseen by the U.S. Office of Personnel Management (OPM) and are similar to the other Qualified Health Plan products offered on the Marketplace. The name "Multi-State Plan or MSP" does NOT mean that consumers have health plan coverage for non-urgent care in multiple states.

Dental

We offer an individual and family dental plan to fit your health care needs and budget:

- Anthem Dental PPO

Anthem can help you get access to the dental care you need for your overall health. Our dental plan covers you 100% for exams, cleanings and X-rays. Plus, we have one of the largest dental preferred provider organization (PPO) networks in the country. To see more of what we cover, take a look at the **Dental stand-alone plans** on the next page.

Tools that put a smile on your face

We offer some great online tools to help you better understand your dental health. Once you're a member, log in to the web address on your ID card to access:

Ask a Hygienist

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

Dental Cost Estimator

Help estimate your costs for certain dental procedures and services in the ZIP code where you get care.

Dental Health Assessment

Get feedback based on your unique responses to a few questions to help you keep a healthy smile.

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.

Dental stand-alone plans

	Anthem Family Dental PPO (1FQW) (Dependents age 18 and younger)	**Anthem Family Dental PPO (1FQW)** (Adults age 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[1] $130 per family[1]	$50[1]
Annual Maximum (per person)	None	$1,500
Annual out-of-pocket limit	$350[2] / None	None
Diagnostic and preventive	No waiting period	No waiting period
Cleaning, exams and 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	Covered[2]
Complex & major services	No waiting period	6-month waiting period[3]
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 orthodontia	Not covered	Not covered
International emergency dental program	Included	Included

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

Please see Dental stand-alone plans footnotes on page 23.

Dental stand-alone plans footnotes

1 With our Dental Blue PPO Basic and Dental Blue PPO Enhanced Plans, the deductible is waived for **Diagnostic and Preventive** services received in our network.

2 Per child, up to $700 per family.

3 The six-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 plan — 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 resources

Whether you're looking for one-on-one coaching or pregnancy 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 — is staffed with registered nurses who are just a phone call away at any time. Nurses can answer questions about a medical concern or help you choose the right level of care. Plus, you can call the same phone line and listen to hundreds of health topics in the AudioHealth Library.

Care Support — gives you the extra care and support you need for your ongoing or complex health issues. A case manager may call you to see how we can help keep your condition in check and give you information as well as emotional support services.

And don't forget about those regular checkups! Your yearly exams, flu shots and other preventive care services are covered 100% when you visit in-network providers. These services can give you extra support in managing your health or a specific health condition.

MyHealth Advantage — helps keep you healthier. We review your incoming health claims and remind you if you've missed a routine test or checkup. We also check the medications you take in the event your doctor needs to be alerted of possible drug interactions or if you could save money. If we find something that can help you, we'll mail you a confidential MyHealth Note. Or, download the Anthem Anywhere app and choose to receive your personalized, secure health messages on-the-go through the Mobile Inbox.

SpecialOffers@Anthem℠

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

Through the program, members can 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**.

* 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 (EHPC) is a kind of doctor-patient relationship created just for Anthem PPO and EPO 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.
- Helps to improve 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.

To find out if your primary care doctor is in the EPHC program, go to **anthem.com/ca/findadoctor**. If your doctor is in the program, you'll see Quality Snapshot within the doctor's listing and the EPHC designation (a heart symbol with a plus sign) under Other Certifications.

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

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.

Our secure website:

- 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.
- Manage your prescription benefits and search the drug list that applies to your benefit plan.

Our Anthem Anywhere app:

- Find a doctor, hospital or pharmacy
- Get a virtual ID card
- Compare doctor costs and quality
- Manage prescription benefits
- View claims

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

Now you can have a private video visit with a doctor or therapist on your smartphone, tablet or computer. LiveHealth Online* is an easy and convenient way to get the care you need from the comfort and privacy of home.

All you have to do is sign up at **livehealthonline.com** to use it!

- Get medical advice, diagnoses, proper treatment and even prescriptions, 24/7 in about 10 minutes or less
- Quickly address common health problems, like allergies, colds, rashes, fever and more

Now, you can talk to a licensed therapist or psychologist at home. If you're feeling stressed, worried or having a tough time, we're here to help.

- See a therapist in four days or less†
- Choose a time that's convenient for you - seven days a week from 7 a.m. to 11 p.m.

Doctors typically charge $49 or less per visit and therapists usually cost the same as what you'd pay for an office therapy visit, depending on your medical plan.‡

Register at anthem.com/ca for online access.

Once you're a member, register at **anthem.com/ca** to access your benefits online. And don't forget to download the **Anthem Anywhere** mobile app, so you can manage your benefits at home or on the go.

* LiveHealth Online is the trade name of the Health Management Corporation.
† Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications.
‡ Depending on your coverage, the cost may be similar to what you would pay for an office visit, considering your benefits, copay or coinsurance.

Ready to enroll? Let's get started.

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:

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

Then, you can:

4. **Call your Anthem Authorized Agent** to enroll or learn more about our health care plans; or
5. **Visit our website** at anthem.com/ca and apply online; or
6. **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, 2016 through January 31, 2017. Be sure to enroll by December 15, 2016, to start coverage effective January 1, 2017.

There are special qualifying events that may allow you to change your health coverage outside of the open enrollment period. Check with your Anthem Authorized Agent to see if you qualify or if you have other questions about open enrollment.

Your Anthem Authorized Agent can help you enroll. You can also apply online at anthem.com/ca or coveredca.com.

Simplified payments

You can set up a recurring payment using electronic funds transfer (EFT) or bank draft, which means your premium will automatically be paid from your bank account each month.

You can also use WebPay to make your monthly payments. This payment program allows you to enroll in automatic recurring payments with a Visa or MasterCard debit or credit card.

If you choose to make regular credit card payments, make sure your card's expiration date and other account information stays up to date.

We want you to be satisfied

After you enroll in one of our plans, you'll have access to an *Agreement* that explains the 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 coverage 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 **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
- Premiums
- Deductibles, copays, coinsurance and out-of-pocket limits

There may also be changes to our prescription formulary/drug list, and pharmacy and provider networks during the year.

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 legal 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 don't 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 Review

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

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

We may do a pre-service review before a member goes to the hospital or has other types of services or treatment. Here are some types of medical treatments that might call for a pre-service 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
- 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, such as physical therapy or durable medical equipment. The utilization review team looks at the member's medical information at the time of the review to see if the treatment is medically necessary.

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

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

Case Management

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

Precertification

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

Here's how getting precertification can help you out:

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

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

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

Preferred Provider Organization

A Preferred Provider Organization (PPO) 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 don't 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.

For assistance locating in-network providers, contact us at **855-383-7247** or visit our **Find a Doctor** tool at anthem.com/ca/findadoctor. 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 don't 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.

Exclusive Provider Organization

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

In-network providers have an agreement in effect with Anthem and have agreed to accept the maximum allowed amount as payment in full. Out-of-network providers don't 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.

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 don't 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.

Health Maintenance Organization

Health Maintenance Organization (HMO) plans include contracted hospitals, clinics, doctors and other providers. With this type of plan, only HMO providers can provide you health care. If you select an HMO plan, you will also need to select a primary care physician (PCP). Or, you can have one assigned to you. The PCP will be your "gatekeeper," or person who evaluates your needs and access to health care. You will need a referral from your PCP to see an in-network specialist. Only services received from an in-network provider are covered under this plan. In case of an emergency, coverage will be given even if you are outside of this network.

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 the 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 the Agreement
- Workers' compensation

Medical Loss Ratio

Law requires us to tell you that Anthem Blue Cross' medical loss ratio (MLR) for 2015 was 80.0%. 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 PPO plans are issued by Anthem Blue Cross - Anthem Bronze 60 PPO; Anthem Bronze 60 HDHP PPO; Anthem Silver 70 PPO, an MSP; Anthem Silver 73 PPO, an MSP; Anthem Silver 87 PPO, an MSP; Anthem Silver 94 PPO, an MSP; Anthem Gold 80 PPO, an MSP; Anthem Platinum 90 PPO; and Anthem Minimum Coverage PPO.

The following HMO plans are issued by Anthem Blue Cross - Anthem Silver 70 HMO, 73 HMO; Anthem Silver 87 HMO; Anthem Silver 94 HMO; Anthem Gold 80 HMO; and Anthem Platinum 90 HMO.

The following EPO plans are issued by Anthem Blue Cross - Anthem Bronze 60 EPO; Anthem Bronze 60 HDHP EPO; Anthem Silver 70 EPO, an MSP; Anthem Silver 73 EPO, an MSP; Anthem Silver 87 EPO, an MSP; Anthem Silver 94 EPO, an MSP;Anthem Gold 80 EPO, an MSP; Anthem Platinum 90 EPO; and Anthem Minimum Coverage EPO.

While we sell HMO plans throughout California, the products are not available in some areas. Below is a list of excluded ZIP codes:

HMO plans not offered in these zip codes:

El Dorado: 95613, 95619, 95623, 95633, 95636, 95656, 95667, 95684, 95709, 95720, 95721, 95726, 95735, 96142, 96150, 96151, 96152, 96154, 96155, 96156, 96157, 96158
Placer: 95701, 95714, 95715, 95717, 96140, 96141, 96143, 96145, 96146, 96148
Los Angeles: 90313, 90397, 90398, 90612, 90623, 90630, 90631, 90659, 90704, 90822, 90845, 90888, 91131, 91191, 91310, 91354, 91363, 91383, 91384, 91390, 91399, 91497, 91709, 91797, 91799, 91841, 93243, 93532, 93544
Sacramento: 95641
Santa Clara: 95020, 95021, 95038, 95046
Riverside: 91720, 92201, 92202, 92203, 92210, 92211, 92225, 92226, 92234, 92235, 92236, 92239, 92240, 92241, 92247, 92248, 92253, 92254, 92255, 92258, 92260, 92261, 92262, 92263, 92264, 92270, 92274, 92276, 92282, 92292, 92330, 92343, 92561
San Bernardino: 91798, 92242, 92252, 92256, 92267, 92268, 92277, 92278, 92280, 92284, 92285, 92286, 92301, 92304, 92309, 92310, 92314, 92315, 92323, 92332, 92333, 92338, 92342, 92347, 92356, 92363, 92364, 92365, 92366, 92386, 92414, 92424, 93555, 93558, 93562, 93592
San Diego: 91905, 91906, 91916, 91934, 91948, 91962, 91963, 91980, 91987, 91990, 92004, 92066, 92070, 92086, 92090, 92133, 92194
Yolo: 95606, 95607, 95627, 95637, 95645, 95679, 95698, 95937

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

It'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.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-634-3381). (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 Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-634-3381). (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-634-3381). (TTY/TDD: 711)

Armenian
Եթե այս փաստաթուղթն անհրաժեշտ լինի Ձեզ այլ լեզվով, կարող եք խնդրել այն Անդամների սպասարկման կենտրոնից՝ զանգահարելով (855-634-3381) հեռախոսահամարով: Այն Ձեզ անվճար կտրամադրվի: (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-634-3381)請求免費協助。(TTY/TDD: 711)

Farsi
در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید،
می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با
مرکز خدمات اعضاء به شماره 855-634-3381 تماس بگیرید، (TTY/TDD: 711)

Hindi
अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-634-3381) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Hmong
Yog hais tias koj xav tau kev pab txhawm rau kom nkag siab txog daim ntawv no hais ua lwm hom lus, tej zaum koj kuj yuav thov tau yam tsis xam tus nqi dab tsi ntxiv hlo li uas yog hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab (855-634-3381). (TTY/TDD: 711)

Japanese
この書面を他の言語で理解するための支援が必要な場合には、メンバーサービス番号（855-634-3381）に電話して支援を求めることができます。追加費用はかかりません。(TTY/TDD: 711)

Khmer
បីអ្នកតម្រូវការជំនួយក្នុងការយល់ពីឯកសារនេះជាភាសាផ្សេង អ្នកអាចស្នើវាដាយឥតគិតថ្លៃបែន្ថមែដាយហៅទូរស័ព្ទទៅលេខសេវាសមាជិក (855-634-3381)។(TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-634-3381)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Punjabi
ਜੇ ਤੁਹਾਨੂੰ ਕਿਸੇ ਬਦਲਵੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਤੁਸੀ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ (855-634-3381) ਤੇ ਕਾਲ ਕਰਕੇ ਕਿਸੇ ਵਾਧੂ ਲਾਗਤ ਦੇ ਬਿਨਾਂ ਇਸ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-634-3381). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-634-3381). (TTY/TDD: 711)

Thai
หากท่านต้องการความช่วยเหลือเพื่อทำความเข้าใจเกี่ยวกับเอกสารนี้ในภาษาอื่น ท่านอาจขอรับบริการได้โดยไม่เสียค่าใช้จ่ายเพิ่มเติมใดๆ โดยโทรไปที่หมายเลขฝ่ายบริการสมาชิก (855-634-3381) (TTY/TDD: 711)

Vietnamese
Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-634-3381). (TTY/TDD: 711)

Get help today!

To learn more, call your Anthem Authorized Agent. You can also view and compare plans online at **anthem.com/ca**.

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

Your HSA:

Enjoy the advantages of opening a Health Savings Account (HSA) from BenefitWallet®

A Health Savings Account can help you pay for health care expenses including prescriptions. Plus, you can claim your HSA contributions as tax deductions, earn interest on your money and roll over the year-end balance.

To realize your plan's full power, consider selecting a qualified high-deductible health plan with an HSA. Our partner, BenefitWallet, administers our HSA solution with The Bank of New York Mellon as the custodian. Setting up your account with BenefitWallet is easy and it comes with built-in advantages and conveniences like:

- A single Customer Service contact for the health plan and your HSA
- A single online health site to access your plan benefit information and account details
- Several payment and deposit options, including debit cards, checks and automatic fund transfers
- Ability to save your receipt images online
- Competitive interest rates and investment opportunities for the funds in your account
- iPhone®, iPad® and Android™ apps for access anywhere
- Health Topics encyclopedia of more than 1,500 ailments
- Medication Advisor for drugs and pharmacy identifier
- Treatment Cost Advisor for common medical conditions
- FDIC-insured checking account with the custodian, The Bank of New York Mellon (BNY Mellon)

Note: You also have the option of using a different financial institution to set up your Health Savings Account.

Set up is easy

Simply make the selection on your application form and we'll send you welcome materials to get you started. Account registration instructions are included. It's that simple.

Anthem® BlueCross®

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A closer look at your BenefitWallet HSA

BenefitWallet Welcome Materials

If you make the selection on your application form, your HSA will automatically be set up - no set-up fee required. You'll soon receive HSA welcome materials with all of the instructions for opening and using your account. A separate application for your account is only required if you choose an HSA administrator other than BenefitWallet.

Interest and investments

You'll earn interest on your HSA funds and have the chance to invest your funds as long as you keep a minimum $1,000 HSA balance. Investment options include a number of mutual fund families. Once you're ready to invest, log in to your account and select "Investments" from the Quick Links menu or contact the BenefitWallet Service Center at **866-686-4798,** Monday through Friday, from 8 a.m. to 11 p.m. ET.

Debit cards, checkbooks and online bill pay

Use your VISA debit card, your HSA checkbook or online bill pay (provided by BenefitWallet) to pay your doctor or pharmacy directly for eligible medical expenses — or to reimburse yourself for qualified medical expenses paid out of pocket.

Deposits to your account

You can make your deposits online or with a mobile app. You can also send a check and deposit slip to the address printed on your deposit slip. Deposit slips can be found at the back of the checkbook, online through the Help Center or through the BenefitWallet Service Center. In addition, you can set up an electronic funds transfer between your bank and BenefitWallet for one-time or recurring account contributions.

Account activity statement

Regularly, you'll receive an electronic statement from BenefitWallet that shows all your account activity. Your monthly statement is free if you open your account electronically. You can receive a paper statement for an additional fee of $1.25 per month. Visit anthem.com/ca or call your dedicated Customer Service line to learn how to elect this option. You'll also receive *IRS 1099* and *IRS 5498* forms from BNY Mellon near tax time to help with tax preparation.

BenefitWallet HSA fee and rate schedule

A *Deposit Agreement* and *Disclosure Statement,* along with a *Rate and Fee Sheet* will be made available to you by BenefitWallet. Please refer to those documents for the complete terms and conditions related to your account.

As appealing as these options may sound, you should still talk to your tax advisor when trying to maximize financial benefits for your personal situation.

Banking fees	
Monthly account fee	$2.95
First two debit cards, debit card transactions, first checkbook, check writing, online bill pay, electronic transfers	no charge
ATM transactions	$2
Card replacement Duplicate check	$5
Check reorder	$10
Nonsufficient funds	$25
Stop-check service	$25
Periodic paper statement	$1.25

This is what the IRS requires if you want to open a Health Savings Account:

- **You must be covered by an HSA-compatible, high-deductible health plan.**
- **You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa.**
- **You cannot be covered by any other medical plan that is not an HSA-compatible, high-deductible health plan.**
- **You cannot be enrolled in Medicare.**
- **You cannot be claimed as a dependent on another individual's tax return.**
- **If you are a veteran, you may not have received veteran's benefits within the last three months.**
- **You cannot be active military.**
- **Your spouse cannot be enrolled in an FSA plan.**