The enrollment period runs
October 15, 2018 - January 15, 2019

Anthem

How to choose and use your health plan

Get the answers you need
with this helpful guide

California

2019 Plan Year

Individual and Family

Bronze, Silver, Gold, Platinum and Minimum Coverage EPO plans offered by Anthem Blue Cross

Certified by Covered California

05522CAMENABC 9/18

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What you need to know to choose a plan that's right for you.

Your options for coverage

Medical plans: Our individual and family health insurance plans give you lots of options. You'll get preventive care, such as screenings and flu shots, for as low as $0, with no copay from **in-network** doctors (doctors in your plan). Plus, you won't have to meet your deductible first. And you'll have the health insurance you need in case of an emergency or illness.

Dental/vision: With our health plans, you'll get pediatric essential health benefits for dental and vision. For extra coverage, Anthem offers stand-alone dental and vision insurance for you and your whole family, with great care from leading doctors. Whether it's dental or vision you're looking for, we've got a plan for you.

Term Life insurance: Anthem Life Insurance Company now offers low cost term life insurance coverage. Our Individual term life plans include two coverage options: $25,000 and $50,000. You can choose the coverage amount that fits your needs. Life insurance is an important decision, but it doesn't have to be a complicated one. Term Life Insurance underwritten by Anthem Life Insurance Company.

Pharmacy: Pharmacy is the most widely used benefit—4X more than medical—and often the first benefit members access.[1] Getting the most out of your pharmacy benefits can help keep you healthy and save you money.

- **Your covered medications:** To see if your drug is covered, go to anthem.com/ca/pharmacyinformation and choose the link, **Individual Select Drug List**.
- **Retail Pharmacies:** Your pharmacy benefit includes nearly 70,000 retail pharmacies nationwide. To see if your preferred pharmacy is in the plan's network, visit anthem.com/ca/pharmacyinformation/rxnetworks.html.
- **Home Delivery:** Get your medicine delivered right to your door. People who use home delivery pharmacy are more likely to follow their drug treatment plan and have better health outcomes.

To learn more, call your Authorized Agent.

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.

Our retail and home delivery networks are owned and operated by our pharmacy benefit manager, Express Scripts.

1 Retail Prescription Drugs Filled at Pharmacies (Annual per Capita) (accessed 2/16/2017): kff.org; Ambulatory Care Use and Physician office visits, US Centers for Disease Control and Prevention (accessed 2/16/2017), https://www.cdc.gov/nchs/fastats/physician-visits.htm; https://www.cdc.gov/nchs/fastats/drug-use-therapeutic.htm; and http://www.statista.com/chart/2689/americans-dont-like-visiting-the-doctor (accessed June 17, 2015).

Answers to your questions

Why choose Anthem?

When you choose an individual or family insurance plan with Anthem, you'll have access to leading doctors and hospitals. It's important to us that you see the doctor you want and get the care you need.

You'll see the difference with Anthem. You can select great doctors, care centers and hospitals from our network of providers. You can also have a private video visit with a doctor or therapist on your smartphone, tablet or computer. It's one of the best ways for us to help support your health and the health of your family.

Access to preventive care

At Anthem, we believe that prevention is the best medicine. Preventive care is offered for as low as $0 with no copay and no deductible to meet when received from doctors in your plan.

With us, you can also count on:

- Dedicated customer service.
- One source for all your benefits, including dental, vision and term life.
- A simple enrollment process.
- Resources to support your health care goals.

Why do I need coverage?

The short answer is ... life happens and it helps to be ready. No one plans to break an arm or catch pneumonia. That's why having a health care plan is so important. It helps you:

- Pay for those unexpected costs that come with a serious illness or injury.
- Get some important benefits like preventive care that can help you stay healthier and get more effective treatment.

Still not convinced? Here are three reasons why coverage is so important:

1. **It's worth the price.** Have you ever thought about what the cost would be to have a major surgery without health insurance? Now picture adding that in with your mortgage/rent and monthly expenses. That's a case where monthly payments for coverage are small compared to footing the bill for a major unexpected cost.
2. **It helps you stay on top of checkups.** When you have coverage, you'll be much more likely to use it to get your yearly checkups and tests that can catch issues early. Plans even include preventive care at no extra cost when you use doctors in your plan (in-network doctors).
3. **It's an investment in you.** You insure your home and cars, so why would you put yourself at the bottom of the list? Think about how much it would cost to fix you if something serious were to happen.

Answers to your questions

What coverage do I need?

Choosing the right plan for you can be a challenge. We get that. So let's start with some questions to figure out what works best for 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?
- **Is a Catastrophic plan an option?** If you're under age 30 (or are 30 or older with an approved hardship exemption from Covered California) you may qualify for a high-deductible, lower monthly payment, Catastrophic plan. Catastrophic plans can help protect you from worst-case scenarios like serious accidents or illnesses.

Plan choices

Metal Levels

- **Bronze:** You'll have lower monthly payments while being covered for check ups and preventive care. You could pay more out of pocket if you need more care, but if you don't expect to go to the doctor very much this year, Bronze may be a good bet. These health plans can be great for people who are younger with no dependents.
- **Silver:** You'll get health coverage that covers all the basics and more. Silver plans on Covered California offer the greatest assistance for both tax credits and cost sharing subsidies if you qualify.
- **Gold:** You'll have higher monthly payments but lower out of pocket costs depending on the services you use. In CA, Gold EPO has a $0 deductible and you can save on visits to doctors or specialists when you need them.
- **Platinum:** On this plan, your monthly payments are higher, but you're covered for emergencies, regular doctor visits, and preventive care alike, with little or no deductible. It's broad coverage with out of pocket savings for individuals and families.

Can I afford it?

If you're thinking coverage might cost too much, you're not alone. But, what you might not know is that you may be able to get help paying for it. And a health insurance subsidy may be the answer. Don't know what a subsidy is? That's just a fancy word for getting financial help from the government to help you pay for your health care coverage.

You could be eligible for a subsidy, also called an advanced premium tax credit, to lower your monthly payment. You may also qualify for a plan where you'll pay less for your out-of-pocket costs.

Other ways to help save money:

Check if your favorite doctor, hospital or other health care provider is in your plan. That way you can make sure you get your care at the lower or negotiated network rate.

You can also save money by only using the emergency room (ER) for emergencies. Head straight to the ER or call 911 for serious health issues. Otherwise, save yourself money and time by visiting your primary care doctor, an urgent care center, or LiveHealth Online for minor medical issues.

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.

With a qualified high-deductible plan, you can set up the HSA through a bank and fund it with your post tax dollars. Before selecting an HSA plan, check with your tax advisor to see if an HSA plan is right for you.

Answers to your questions

How do I find a doctor or hospital?

You can find an in-network doctor, hospital, dentist, pharmacy and more by using our **Find a Doctor tool**. It's quick and easy. Plus, you'll get the most from your health care coverage (and save money), if you choose a doctor or hospital in your plan. Follow these simple steps:

1. Go to **anthem.com/ca**.
2. Choose **Individual & Family** at the top of your screen. Then under **Care** select **Find a Doctor**.
3. Scroll past Search as a Member to **Search as Guest**.
4. Choose **Search by Selecting a Plan or Network** and complete the form.

The difference between in-network doctors and out-of-network doctors

In-network Doctors:	Doctors and other health care providers who contract with us to provide care at discounted rates.
Out-of-network Doctors:	Doctors and other health care providers who are not contracted with the health plan.

What should I know about my network?

- **Exclusive provider organization (EPO):** With our EPO plans, you'll be able to see any in-network doctor. It's a good idea to have a primary care doctor to coordinate your care, so we'll pick 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, ambulance services or when a service is preapproved. If you see a doctor not in your plan for any other reason, you'll have to pay 100% out of pocket.

Anthem advantages

Making informed health care decisions for you and your family is simple with our website, mobile app and helpful tools, like Estimate Your Cost.

No matter which plan you choose, you can register at anthem.com/ca or on the Anthem BC Anywhere mobile app to get personalized information about your health plan.

Use the self-service tools on our secure website to:

- See your claims and coverage details.
- Estimate your costs on common procedures, before you step into the doctor's office.
- Manage your prescription benefits and search the drug list that applies to your plan.
- Check the price of a drug or refill a prescription.
- Make your monthly payments online.

With our Anthem BC Anywhere mobile app, you can:

- Find a nearby doctor, specialist, urgent care center or hospital.
- Download a virtual member ID card.
- Manage your prescription drug benefits.

LiveHealth® ONLINE

You can also take advantage of resources like LiveHealth Online:

Talk to a doctor whenever, wherever with LiveHealth Online	LiveHealth Online Psychology offers virtual counseling
Easy: Connect to a doctor 24 hours a day, from a computer, tablet, or smartphone. **Face-to-face**: Chat by two-way video for common health issues. **Save:** On average members save up to $201 for care, compared to ER, urgent care, or other health facilities.*	**Convenient:** Sessions go from 7 a.m. to 11 p.m., coast-to-coast. **Quick access:** Schedule a visit and be seen within four days, or on demand. **Same cost:** Cost-share is the same as it is for in-office Mental Health/Substance Use therapy benefits.

*Results based on internal LiveHealth Online study during 2014 and first quarter, 2015.

Anthem advantages

Plans include other features to help you and your family stay healthy at no additional cost.

- **24/7 Nurseline:** Our registered nurses can answer your health questions wherever you are – any time, day or night. All you have to do is call.
- **Care Support:** If you need extra care for ongoing or complex health issues, a case manager may call you. Your case manager can answer your questions, set up care with different doctors and help you use your health benefits.
- **MyHealth Advantage:** Avoid health issues, stay healthy and save money. This program tracks your health information to see if there's anything you can do to improve your health. If so, you'll get a personalized and confidential MyHealth Note in the mail.

Peace of mind when you travel.

Travel a lot? Don't worry. You're covered.

Whether you're traveling for work or on vacation, going to the ER or urgent care is the last thing you want to worry about. The good news is you don't have to! All of our plans cover medically necessary emergency and urgent care in all 50 states and internationally, even when you're not using your plan's doctors and hospitals.

Through the Blue Cross Global Core® Service Center, members get claims support, referrals to providers, translations services and medical monitoring 24/7, for services outside the United States, Puerto Rico and the U.S. Virgin Islands.

Simplified payments

We know life gets busy, so we're making it easier for you to pay your monthly payments.

- Set up electronic funds transfer (EFT) or bank draft.
- Enroll in WebPay to use with a Visa or MasterCard debit or credit card.
- Download our Anthem BC Anywhere app and pay with a credit card or your bank account. You can even set up autopay in the app.

You can set up automatic monthly payments with each option. Just make sure your card account information and expiration date stays up to date.

Plan benefit chart - 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 in Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Nevada, Plumas, San Joaquin, Santa Clara, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne and Yuba counties.

	Anthem Bronze 60 HDHP EPO (36TK)	**Anthem Bronze 60 EPO (36TG)◊**	**Anthem Silver 70 EPO (36U2)**
Network name	Pathway X – EPO	Pathway X – EPO	Pathway X – EPO
Plan includes out-of-network coverage?	No	No	No
Individual deductible	$6,000	$6,300	$2,500
Individual out-of-pocket limit	$6,650	$7,550	$7,550
Coinsurance (percentage may vary for some covered services)	40%	100%	20%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[2,3] (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	$40 copay, deductible waived
Office visit: specialist[3] (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	$80 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	$75 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[3]	Deductible, then 40% coinsurance	$75 copay per visit for the first 3 visits, then deductible and $75 copay	$40 copay, deductible waived
Emergency room care (Copay, if applicable, 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[4] (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2, 3, 4: Medical deductible applies	Tiers 1, 2, 3, 4: $500 Combined pharmacy deductible	Tiers 1, 2, 3, 4: $200 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	$40 copay, deductible waived
Speech therapy	Deductible, then 40% coinsurance	$75 copay, deductible waived	$40 copay, deductible waived

Please see Medical and Silver cost-share reduction plans footnotes on page 12.

Plan benefit chart - 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 in Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Nevada, Plumas, San Joaquin, Santa Clara, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne and Yuba counties.

	Anthem Gold 80 EPO (36TZ)	**Anthem Platinum 90 EPO (36TD)**	**Anthem Minimum Coverage EPO (36TA)**
Network name	Pathway X – EPO	Pathway X – EPO	Pathway X – EPO
Plan includes out-of-network coverage?	No	No	No
Individual deductible	$0	$0	$7,900
Individual out-of-pocket limit	$7,200	$3,350	$7,900
Coinsurance (percentage may vary for some covered services)	20%	10%	0%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[2,3] (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[3] (Other office services may be subject to deductible and plan coinsurance)	$55 copay	$30 copay	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	$55 copay	$30 copay	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	20% coinsurance	10% coinsurance	Deductible, then 0% coinsurance
Urgent care[3]	$30 copay	$15 copay	0% coinsurance per visit for the first 3 visits, then deductible and 0% coinsurance
Emergency room care (Copay, if applicable, 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[4] (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2, 3, 4: No deductible	Tiers 1, 2, 3, 4: No deductible	Tiers 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 12.

Silver cost-share reduction (CSR) plans - EPO

73% Silver CSR, 87% Silver CSR and 94% Silver CSR plans are available if you qualify for a tax credit subsidy or cost share reduction on Silver plans you buy through Covered California. Have questions? Call your Anthem Authorized Agent.

	Anthem Silver 70 EPO (36U2)	Anthem Silver 73 EPO (36U5)	Anthem Silver 87 EPO (36U6)	Anthem Silver 94 EPO (36U7)
Network name	Pathway X – EPO	Pathway X – EPO	Pathway X – EPO	Pathway X – EPO
Plan includes out-of-network coverage?	No	No	No	No
Individual deductible	$2,500	$2,200	$650	$75
Individual out-of-pocket limit	$7,550	$6,300	$2,600	$1,000
Coinsurance (percentage may vary for some covered services)	20%	20%	15%	10%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[2,3] (Other office services may be subject to deductible and plan coinsurance)	$40 copay, deductible waived	$35 copay, deductible waived	$15 copay, deductible waived	$5 copay, deductible waived
Office visit: specialist[3] (Other office services may be subject to deductible and plan coinsurance)	$80 copay, deductible waived	$75 copay, deductible waived	$25 copay, deductible waived	$8 copay, deductible waived
Outpatient diagnostic tests (Ex. X-ray, EKG)	$75 copay, deductible waived	$75 copay, deductible waived	$30 copay, deductible waived	$8 copay, deductible waived
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	$300 copay, deductible waived	$300 copay, deductible waived	$100 copay, deductible waived	$50 copay, deductible waived
Urgent care[3]	$40 copay, deductible waived	$35 copay, deductible waived	$15 copay, deductible waived	$5 copay, deductible waived
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	$350 copay, deductible waived	$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 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	20% coinsurance, deductible waived	15% coinsurance, deductible waived	10% coinsurance, deductible waived
Pharmacy deductible[4] (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2, 3, 4: $200 Combined pharmacy deductible	Tiers 1, 2, 3, 4: $175 Combined pharmacy deductible	Tier 1: No deductible Tiers 2, 3, 4: $50 Combined pharmacy deductible	Tiers 1, 2, 3, 4: No deductible
Retail pharmacy tier 1	$15 copay	$15 copay	$5 copay	$3 copay
Retail pharmacy tier 2	$55 copay	$50 copay	$20 copay	$10 copay
Retail pharmacy tier 3	$80 copay	$75 copay	$35 copay	$15 copay
Retail pharmacy tier 4	20% coinsurance (up to $250 per script)	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	$40 copay, deductible waived	$35 copay, deductible waived	$15 copay, deductible waived	$5 copay, deductible waived
Speech therapy	$40 copay, deductible waived	$35 copay, deductible waived	$15 copay, deductible waived	$5 copay, deductible waived

Please see Medical and Silver cost-share reduction plans footnotes on page 12.

Medical and Silver cost-share reduction plans benefit footnotes

◊ With our Anthem Bronze 60 EPO (36TG) 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.

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

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

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

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

Understanding insurance terms

Let’s take a look at some common insurance terms you probably see a lot.

Here’s what they mean:

Coinsurance: Your percentage of the costs. After you meet your deductible, this is your percentage of costs each time you get care and then your plan covers the rest up to the maximum allowed amount. In-network providers agree to accept Anthem's maximum allowed amount as their charge.

Copay: This is a set dollar amount you pay for covered services, such as doctor visits. The amount can vary based on covered service.

Deductible: This is the set dollar amount you pay before we begin paying for most covered health services you receive. **In-network** covered preventive services don’t require a deductible. Your deductible applies to the calendar year (January 1 through December 31), even if your effective date (the date coverage begins) is later than January 1.

Drug tiers: Drugs on a drug list or formulary are typically arranged in tiers. Your cost depends on which drug tier your drug is in.

In-network coverage: This refers to doctors, hospitals, dentists, pharmacies and other care providers who are part of the plan’s network or are in the plan. EPO plans only include coverage for in-network benefits, except for emergency and urgent care, ambulance services, or when a service is pre-approved.

Out-of-network coverage: This refers to doctors, hospitals, dentists, pharmacies and other care providers who don’t participate in the plan or network. EPO plans don’t offer out-of-network benefits, except for emergency and urgent care, ambulance services, or when a service is pre-approved.

Out-of-pocket limit: This is the maximum amount you can pay out of your pocket for covered services each year. Once you reach that limit, which varies by plan, we cover the rest up to the maximum allowed amount. In-network providers agree to accept Anthem's maximum allowed amount as their charge.

Plan name: Plan name and contract code are found on 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.

Ready to enroll? Let's get started.

Help is close at hand:

Call your Anthem Authorized Agent to enroll or learn more about our health care plans; or

Visit our website at anthem.com/ca and apply online; or

Find our plans through Covered California at **coveredca.com**.

You can buy health care plans once a year through a sign up period. This year, the sign up period runs from **October 15, 2018 - January 15, 2019**. Be sure to enroll by December 15, 2018, to start coverage effective January 1, 2019.

You may be able to change your health coverage outside of this sign up period if there are special qualifying events. Check with your Anthem Authorized Agent to see if you qualify or if you have other questions.

We want you to be satisfied

After you enroll in one of our plans, you'll have access to your *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.

Summary of benefits and services

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 broker or Anthem Authorized Agent


Go to anthem.com/ca.

To access a ***Summary of Benefits and Coverage (SBC)***, please visit **sbc.anthem.com** and select **NEXT** for Summaries in English or Spanish. Other languages can also be selected.

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

In compliance with the Affordable Care Act (ACA), the following plan changes may occur annually on January 1:

- Benefits
- Premiums (monthly payments)
- Deductibles, copays, coinsurance and out-of-pocket-limits

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

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 also 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. An applicant's effective date is determined by Covered California based on the receipt of the completed enrollment form.

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.

Reviewing where services are provided

A service must be medically necessary to be a covered service. The utilization review may include a review of the level of care, type of setting or place of service where services can be safely given to you. If services are given in a higher level of care or cost setting when they could be safely given in a lower level place of care or cost setting, they will not be determined to be medically necessary. The service(s), in that case, are being denied based on the review of where they are provided. When this happens the service(s) can be requested again in another setting or place of care and will be reviewed again for medical necessity. At times, a different type of provider or facility may need to be used in order for the service to be considered medically necessary.

Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a hospital but may be approved if provided on an outpatient basis in a Hospital setting.
- A service may be denied on an outpatient basis if taking place in a hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical center/facility, or in a physician's office.
- A service may be denied at a skilled nursing facility but may be approved in a home setting.

We can do medical reviews like this before, during and after a member's treatment. Here'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;

Important legal information

- 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 get 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.

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 most services, there may be no benefit provided when using an out-of-network provider. You will be responsible for any amount not paid by Anthem when using the services of an out-of-network provider. Please refer to the Summary of Benefits carefully to determine these differences.

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 offer one or more of the following services that may be covered under your Agreement and that you or your family member might need:

- Family planning;
- Contraceptive services, including emergency contraception;
- Sterilization, including tubal ligation at the time of labor and delivery;
- Infertility treatments; or
- Abortion

You should obtain more information before you become a member or select an in-network provider. Call your prospective doctor or clinic, or call Anthem at **855-383-7247** to ensure that you can obtain the health care services that you need.

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

Important legal information

Laws and rights that protect you

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

Exclusions

The specific exclusions are spelled out in the terms of the particular plan, but some of the more common services not covered by these plans are:

- Benefits covered by Medicare or a governmental program, unless otherwise required by law or regulation
- Care provided by a member of your family
- Care received in an emergency room that is not emergency care, except as specified in the Agreement
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Charges greater than the maximum allowable amount (charges exceeding the amount Anthem permits for services)
- Comfort and/or convenience items
- Compound drugs except as described in the Agreement
- Cosmetic surgery
- Custodial care
- Health club memberships and fitness services
- In-vitro (IVF) as described in the Agreement's exclusions
- Nutritional and dietary supplements, except as mandated
- 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 2017 was 88.5%. 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.

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.

California required Notice of Non-discrimination

Anthem does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender identity, sexual orientation, age or disability. For people with disabilities, we offer free aids and services, and information in alternate formats, free of charge and in a timely manner, when necessary to ensure an equal opportunity to participate.

Get help in your language

Curious to know what all this says? We would be too. Here'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 (1-855-634-3381). (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 customer service telephone number at 1-800-627-8797.

Spanish

Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (1-855-634-3381). (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 (1-855-634-3381) (TTY/TDD: 711)

Armenian

Եթե այս փաստաթուղթն անհրաժեշտ լինի Ձեզ այլ լեզվով, կարող եք խնդրել այն Անդամների սպասարկման կենտրոնից՝ զանգահարելով (1-855-634-3381) 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(1-855-634-3381)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 1-855-634-3381 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 (1-855-634-3381) 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 (1-855-634-3381). (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（1-855-634-3381）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

បើអ្នកត្រូវការជំនួយក្នុងការយល់ពីឯកសារនេះជាភាសាផ្សេង
អ្នកអាចស្នើវាដោយឥតគិតថ្លៃបែនថមែដោយហៅទូរស័ព្ទទៅលេខសេវាសមាជិក
(1-855-634-3381)។(TTY/TDD: 711)

Korean

다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(1-855-634-3381)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 ਤੁਸੀਂ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ (1-855-634-3381) 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 (1-855-634-3381). (TTY/TDD: 711)

Get help in your language

Tagalog

Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (1-855-634-3381). (TTY/TDD: 711)

Thai

หากท่านต้องการความช่วยเหลือเพื่อทำความเข้าใจเกี่ยวกับเอกสารนี้ในภาษาอื่น ท่านอาจขอรับบริการได้โดยไม่เสียค่าใช้จ่ายเพิ่มเติมใดๆ โดยโทรไปที่หมายเลขฝ่ายบริการสมาชิก (1-855-634-3381) (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 (1-855-634-3381). (TTY/TDD: 711)

So that's how it all works.

Still have questions? Just ask. We're here to help.

To learn more, call your 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 Authorized Agent.

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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®

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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 **1-866-686-4798** or **1-855-545-4168** (for TDD callers) Mon - Fri 8 a.m. to 11 p.m. (ET); Sat - Sun 9 a.m. to 6 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.**

Peace of mind made easy

Anthem individual term life insurance — affordable and no exam needed

Life insurance is an important decision, but it doesn't have to be a complicated one.

You want your loved ones to be taken care of — even if you're not here to provide for them. That's why it's important to have life insurance to help your family with expenses when the unexpected happens. Anthem individual term life insurance plans can give your family peace of mind for their future. While you may not want to think about it, there's actually no better time than now to protect your family.

To make things even better, we've made it simpler to get coverage:

- There's no medical exam required.
- If you also have a health plan with us, you'll only get one bill for health and life coverage.
- Life insurance is available with Anthem's health coverage or without — it's your choice.

Our individual term life plans include two coverage options: $25,000 and $50,000.

You can choose the coverage amount that fits your needs. Individuals between the ages of 18 and 64 are eligible to apply.

Take a look at how much each plan would cost you:

Anthem individual term life monthly rates

Age	$25,000	$50,000
18	$2.50	$5.00
19-29	$4.65	$9.30
30-39	$5.40	$10.80
40-49	$12.50	$25.00
50-59	$34.80	$69.60
60-64	$49.00	$98.00

Want to know more?

Go to anthem.com for more information or to apply for life insurance. Or call 1-877-212-1796 with any questions.

Anthem®

The initial rates for term life insurance are based on your age at the time the policy is issued and are subject to change in accordance with the published rate table. The policy is issued for a one-year term, renewable at the policyholder's option. Term life insurance is subject to the written provisions of the policy. The policy contains exclusions and limitations, including the exclusion for death due to suicide for the first two years the policy is in force. The policy will terminate at age 65.

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Your prescription drug benefits

Anthem plans help keep you healthy and lower your health care costs

Your medications — covered

All of our pharmacy plans have a drug list that includes hundreds of covered brand-name and generic drugs in every category and class, meeting or exceeding Affordable Care Act (ACA) requirements. Individual and family plans use the Select Drug List.

To view the Select Drug List and see if your drug is covered, go to anthem.com/ca/pharmacyinformation and choose the ***Individual*** **Select Drug List.**

Filling your prescriptions

It's simple. Choose the way that works best for you to get the medicines you need, when you need them.

Home delivery pharmacy – your medicine delivered right to your door

We offer home delivery to make it easier for you to get your medicine quickly and safely. People who use home delivery pharmacy are more likely to follow their drug treatment plan, resulting in increased medication adherence. That means fewer doctor visits and hospital stays — and lower health care costs for you.[1]

Retail pharmacies in your network

Our **National Pharmacy Network** includes nearly 70,000 retail pharmacies — making it easy for you to get prescriptions filled near your home or work, or even when you travel.

Anthem®

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Your pharmacy benefits — easy to manage at anthem.com/ca

Manage all your prescription benefits in one place. It's easy. It's convenient. And you can do things like:

- Find out if your drug is covered. Go to **anthem.com/ca/pharmacyinformation** and choose the ***Individual*** **Select Drug List.**
- See if your preferred pharmacy is in the plan's network.

  Visit **anthem.com/ca/pharmacyinformation/rxnetworks.html** to see all of the pharmacies in our networks, including Level 1 pharmacies where you can save the most money.
- Learn more about your pharmacy benefits — including why some drugs need preapproval to be covered — by going to our frequently asked questions (FAQs) at **anthem.com/ca/faqs/california/pharmacy**.

On the go, too! Most of the same helpful tools are available on your cell phone or other mobile device with the Anthem Anywhere app. You can manage your drug benefits wherever you are, whenever you need to.

Medical + pharmacy — better and easier than ever

With our combined medical and pharmacy benefits, your doctor can see the whole picture of your health. For you, this means:

- Better overall health.
- A smoother experience.
- Fewer hospital stays and lower medical costs.[2]
- Saving more on prescription drugs.[2]

1 Examination of the Link Between Medication Adherence and Use of Mail-Order Pharmacies in Chronic Disease States, Journal of Managed Care & Specialty Pharmacy, Nov. 2016.
2 Integrating pharmacy with medical benefits can help your bottom line, Smart Business Online (sbonline.com), Apr. 2015.
This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the <enter contract name> may be continued in force or discontinued. For more information, review the <enter contract name>, call your Anthem Sales representative or go to anthem.com/ca.

Anthem®