Looking for a new health plan?
We can help.

Anthem BlueCross

2018 Plan Year: California

Individual and Family
Your health plan guide

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

Certified by Covered California

Why Anthem?

Health plans don’t have to be complicated.

We understand that every individual and family is unique. That’s why we offer 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.
- One source for all your benefits, including dental and vision.
- 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, 2017.

Table of Contents

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) required 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.

The Select Drug List has your medication needs covered

Your medical plan uses a formulary or drug list that includes hundreds of covered brand-name and generic drugs. Our individual and family plans use the Select Drug List, which offers drugs in every category and class that meet or exceed ACA requirements. Our drug list helps manage health care costs, while offering you the coverage you need.

To find out if your medication is covered, you can check out our Select Drug List at anthem.com/ca/pharmacyinformation and click on the link, **Select Drug List (Searchable)**.

Save with Home Delivery Choice

We offer home delivery of your medicines right to your door — making it easy for you to get your medicine quickly and safely. People who use home delivery pharmacy are more likely to follow their medication treatment plan — meaning fewer doctor visits and hospital stays. And lower health care costs for you.

How it works:

- You must sign up for home delivery if you are taking medicines for ongoing conditions like indigestion, high blood pressure, high cholesterol or diabetes — either at your local, retail pharmacy or with home delivery.
- We'll call you and send you a letter 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 won't be covered until you get started with the home delivery program.

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

- See if your preferred pharmacy is in the plan's network. Visit anthem.com/ca/findadoctor.
- Learn more about your pharmacy benefits, including why some drugs require prior authorization, by going to our FAQs at anthem.com/ca/faqs/california/pharmacy.

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

When it comes to your health care, we look for ways to give members more value, convenience and control. The Anthem Anywhere app allows members to manage all their prescription benefits right from the palm of their hand:

- Compare retail prescription medication costs with Price a Medication
- Find an in-network pharmacy near you with Locate a Pharmacy
- Track your order status or quickly refill and renew your prescriptions with Order Status and Automatic Refills
- Get personalized reminders to ensure you're following your doctor's treatment plan using Pharmacy Care Alerts

Together with medical – better and easier than ever

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

*Outcomes based on 2014 integrated analysis. Results don't represent a guarantee of outcomes, specific results and cost savings will vary.

How to choose a plan

Saving money on your medical bills is easy. See doctors in your plan. We'll show you how.

When you see a doctor or go to a hospital not in your health care plan, you'll be responsible for 100% of the cost, unless it's an emergency. But don't worry. We're here to help you choose a doctor in your plan to save money.

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 work it out with that same doctor to discount the rate for our Anthem members down to $100. The doctor is in our health care plans as soon as this agreement is made. It's that simple.

Bottom line: Always check to see if your favorite doctor, hospital or other health care provider is in your plan, 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 - 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.

Helpful hint:

Save emergency room visits for emergencies only

If you have a real emergency, head straight to the ER or call 911. Otherwise, save yourself money and time by visiting your primary care doctor or an urgent care center for minor medical issues.

Network details: EPO

- **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 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.

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 get 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.

Outside the U.S. – Our EPO plans also include coverage for medically necessary emergency care when you visit participating BlueCard providers while traveling abroad. Blue Cross Global Core™ 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 more than 9,000 hospitals and 21,000 health care professionals and outpatient care centers around the world.

Through the Blue Cross Global Core Service Center, members get:

- Claims support
- Doctor referrals
- Translation services
- 24/7 medical monitoring

Plus, the Blue Cross Global Core Service Center may also cover 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?

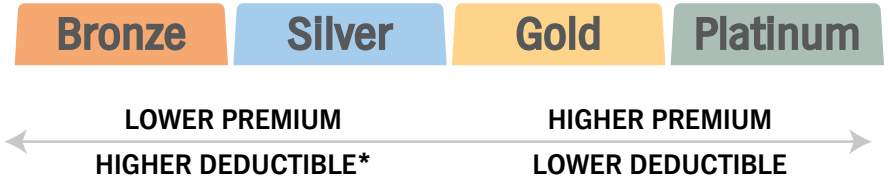
Choosing the right health care plan can be challenging. To help you decide, consider the questions below. And remember, your Anthem Authorized Agent can provide answers and give advice.

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 choose 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 an HSA?**
  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 your plan 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.

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 - 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 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 (2EUX)	**Anthem Bronze 60 EPO (2EUU)°**	**Anthem Silver 70 EPO (2VC5)**
Network name	Pathway X – EPO	Pathway X – EPO	Pathway X – EPO
Plan includes out-of-network coverage?	No	No	No
Individual deductible	$4,800	$6,300	$2,500
Individual out-of-pocket limit	$6,550	$7,000	$7,000
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	$35 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	$75 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	$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[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: $130 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 14.

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 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 (2VC2)	**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	$0	$0	$7,350
Individual out-of-pocket limit	$6,000	$3,350	$7,350
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)	$25 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]	$25 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[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	$25 copay	$15 copay	Deductible, then 0% coinsurance
Speech therapy	$25 copay	$15 copay	Deductible, then 0% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 14.

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 on Covered California. Have questions? Call your Anthem Authorized Agent.

	Anthem Silver 70 EPO (2VC5)	Anthem Silver 73 EPO (2VC8)	Anthem Silver 87 EPO (2VC9)	Anthem Silver 94 EPO (2VCA)
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	$7,000	$5,850	$2,450	$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)	$35 copay, deductible waived	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived
Office visit: specialist[3] (Other office services may be subject to deductible and plan coinsurance)	$75 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	$25 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]	$35 copay, deductible waived	$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	$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: $130 Combined pharmacy deductible	Tiers 1, 2, 3, 4: $130 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	$35 copay, deductible waived	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived
Speech therapy	$35 copay, deductible waived	$30 copay, deductible waived	$10 copay, deductible waived	$5 copay, deductible waived

Please see Medical and Silver cost-share reduction plans footnotes on page 14.

Medical and Silver cost-share reduction plans benefit footnotes

◊ With our 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.

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.

Embedded pediatric dental benefits

Embedded pediatric dental benefits are included with all of our medical plans for members until the end of the month in which they turn 19. Coverage includes preventive care, fillings and some other major services like medically necessary orthodontia.

- Shared deductible for medical and dental services except for dental diagnostic and preventive services on Minimum Coverage plans
- Shared out-of-pocket limit for medical and dental services

	Non-standard medical plans[1]	**Standard medical plans**[2]	**Minimum coverage medical plans**
	in-network / out-of-network[3]	***in-network / out-of-network***[3]	***in-network / out-of-network***[3]
Dental network	Dental Prime		Dental Prime
Deductible[4]	All dental services subject to the medical deductible	No deductible	Dental services subject to the medical deductible except diagnostic and preventative services[5]
Annual maximum (per person)	None	None	None
Annual out-of-pocket limit	Combined with medical	Combined with medical	Combined with medical
Diagnostic and preventive	*No waiting period*	*No waiting period*	*No waiting period*
Cleaning, exams, x-rays	0% / 0% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
Basic services	*No waiting period*	*No waiting period*	*No waiting period*
Fillings	50% / 50% coinsurance	20% / 20% coinsurance	0% / 20% coinsurance
Complex and major services	*No waiting period*	*No waiting period*	*No waiting period*
Endodontic/periodontic/oral surgery	50% / 50% coinsurance	50% / 50% coinsurance	0% / 50% coinsurance
Major services	50% / 50% coinsurance	50% / 50% coinsurance	0% / 50% coinsurance
Medically necessary orthodontia[6]	50% / 50% coinsurance	50% / 50% coinsurance	0% / 50% coinsurance
Cosmetic orthodontia	Not covered	Not covered	Not covered

1 Non-standard plans are based on the Standard Benefit Plan Designs, but differ in some ways to provide more options for cost sharing and deductibles. These are offered only off the Marketplace.
2 Standard plans follow the Standard Benefit Plan Designs from Covered California. These are offered both on Covered California and off the Marketplace.
3 The out-of-network pediatric dental benefits displayed only apply if the medical plan provides for out-of-network coverage.
4 For medical plans where the deductible equals the out-of-pocket maximum, any services subject to the deductible have coinsurance of 0% after deductible.
5 Non-Standard Minimum Coverage (Catastrophic) plans have all dental services subject to the medical deductible.
6 Orthodontia is usually considered dentally necessary when a child's teeth are misaligned (crooked or not spaced correctly) to the point where they don't work properly. This could cause the child to have trouble speaking or eating. Some examples would be (1) if a child can't bite into an apple because they can't close their front teeth together or (2) if a child bites into the gum tissue of the palate (roof of the mouth) when they try to bite down.

Embedded pediatric vision benefits

The following vision care services are covered for members until the end of the month in which they turn 19. Coverage may include eye exams, eye glass lenses, frames and contact lenses. The benefit period is the calendar year (January 1 through December 31).

- If you purchase a Catastrophic plan, you must meet your medical deductible before pediatric vision benefits are paid.
- Out-of-network providers may bill you for any charges that exceed the plan's maximum allowed amount.
- The out-of-network pediatric vision benefits displayed only apply if the medical plan provides for out-of-network coverage.

	Benefit frequency	**Cost share** ***in-network / out-of-network***
Eye exam	Once every benefit period	$0 copay / $0 copay up to maximum allowed amount
Lenses (single, biofocal, trifocal and standard progressive)	Once every benefit period	$0 copay / $0 copay up to maximum allowed amount
Frames	Once every benefit period	Anthem formulary[1] / $0 copay up to maximum allowed amount
Contact lenses (Non-elective)	Once every benefit period[2]	Covered in full / $0 copay up to maximum allowed amount
Contact lenses (Elective/disposable)	Once every benefit period[2]	Anthem formulary[1] / $0 copay up to maximum allowed amount
Low vision services (reading and computer glasses)	Once every benefit period	$0 copay / Not covered (benefits are only available when received from Blue View Vision providers)

1 A collection of frames and lenses that can be purchased for a $0 copay (may differ by provider).

2 Benefits for contact lenses are in lieu of the eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.

Getting the dental plan you need

Standalone coverage from Anthem can help you get the dental care you need for your total health. Many of our dental plans cover you 100% for exams, cleanings and x-rays.

Anthem dental plan

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

- Anthem Family Dental PPO

Anthem has one of the largest dental preferred provider organization (PPO) networks in the country.* Plus, we work with in-network dentists to get deep discounts for you. By seeing a dentist in the plan, you can save an average of 25% to 32% on covered dental services.† To see more of what we cover, take a look at the **Dental plans** on the next page.

Anthem Family Dental PPO plan

You must be enrolled in a Platinum, Gold, Silver or Bronze medical plan available on Covered California to purchase this plan. Our Anthem Family Dental PPO plan offers essential coverage and more:

- Diagnostic and preventive coverage for services like cleanings, exams and x-rays
- Benefits for basic services, such as fillings
- Major services like crowns, periodontal (gum-related) procedures, oral surgery and root canals
- Medically necessary orthodontic coverage for children with no waiting period

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 anthem.com/ca 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.

* Network data from Strenuus, August 2016.
† Internal data, 2015.

Dental plan

Cost share shows what a member pays	Anthem Family Dental PPO (1FQW)	
	(Dependents age 18 and younger)	(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
Complex and 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 plans footnotes on page 19.

Dental plan footnotes

1 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

* 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 (EPHC) is a kind of doctor-patient relationship created just for Anthem 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.‡

Always have your benefit details in hand. Register at anthem.com/ca.

Sign up 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 the 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, 2017 through January 31, 2018. Be sure to enroll by December 15, 2017, to start coverage effective January 1, 2018.

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

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

- 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 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 expiration date 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. 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.

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 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.

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, 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
- 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 2016 was 85.1%. This ratio was calculated after provider discounts were applied, and is based on state and federal regulatory rules and regulations, including the federal MLR regulations.

The following EPO plans are issued by Anthem Blue Cross – Anthem Bronze 60 EPO; Anthem Bronze 60 HDHP EPO; Anthem Platinum 90 EPO; and Anthem Minimum Coverage EPO.

SpecialOffers is a service mark of Anthem Insurance Companies, Inc. Vendors and offers are subject to change without notice. Anthem does not endorse and is not responsible for the products, services or information provided by the SpecialOffers vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members. All other marks are the property of their respective owners. All of the offers in the SpecialOffers program are continually being evaluated and expanded so the offerings may change. Any additions or changes will be communicated on our website, anthem.com/ca. These arrangements have been made to add value for our members. Value-added products and services are not covered by your health plan benefit. Available discount percentages may

change or be discontinued from time to time without notice. Discount is applicable to the items referenced.

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

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 extra 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 Member Services phone 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 (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
បើអ្នកតម្រូវការជំនួយក្នុងការយល់ពីឯកសារនេះជាភាសាផ្សេង អ្នកអាចស្នើវាដោយឥតគិតថ្លៃបែនថ់មែដោយហៅទូរស័ព្ទទៅលេខសេវាសមាជិក (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 ਤੁਸੀ 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)

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)

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®

03678CAMENABC VPOD 7/16

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.**