Individual and family health benefit plans for California

We make it easy

Looking for a new health plan? We can help.

Anthem BlueCross

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

03642CAMENABC 8/14

Health care on your terms

When it comes to individual health care coverage, it's not one-size-fits-all. With Anthem Blue Cross (Anthem) you get a range of options so you can compare plans and find the best coverage for your needs and budget. No one knows what you and your family need better than you. Just let us know and we're here to help when and where you need us.

Take control of your health

When you choose Anthem, you don't just get a health plan. You get a total health coverage solution that can help you live healthier and feel your best, while saving money along the way. With Anthem, you get:

- $0 cost preventive care[1] (like checkups and flu shots) with no deductible or copay when you see in-network providers
- Guaranteed coverage, regardless of your health
- Prescription drug benefits at local and nationally recognized pharmacies, plus a mobile app to help you find a pharmacy, order a refill, check order status and more
- 24/7 NurseLine so you can speak to a nurse any time of the day or night and online support whenever you have questions
- The LiveHealth Online tool that lets you video chat with a doctor through your mobile device or a computer with a webcam about common health concerns like colds and the flu (available with PPO and EPO plans)
- Emergency and urgent care coverage in all states through the Blue Cross and Blue Shield Association's BlueCard® Program
- Care support programs to help you take care of chronic or complex health problems
- MyHealth Advantage program to identify ways to improve your health or save you money
- No lifetime dollar maximums on covered services
- Easy-to-use tools to find a doctor, hospital or pharmacy

Health plans don't have to be hard to figure out. See how easy it can be with Anthem.

- ***Personalized help.*** If you're trying to decide which plan will work best, we've got answers for you.
- ***Access to quality care.*** Make sure you're getting the quality health insurance you want. Make sure you get Anthem.
- ***Reliable customer service.*** Our associates are dedicated to giving you the help you need, when you need it.
- ***Simple.*** Health care coverage isn't always easy to understand. We'll help you make sense of it.
- ***Stable.*** One thing is clear about the changes in health care coverage - you can count on us to be there for you.

Call your Anthem Authorized Agent or visit us online at anthem.com/ca where you can view and compare plan options.

Access the benefits that matter to you

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

What's covered?

- In-network preventive care services, including screenings, and help managing a chronic (ongoing) disease
- Outpatient services
- Emergency services, like going to the emergency room (ER) or urgent care center (when necessary)
- Inpatient services (care received when you stay overnight in a hospital)
- Laboratory services (blood work, screenings)
- Prescription drugs
- Rehabilitative and habilitative services (habilitative services help a person learn, keep or improve skills they may not be developing normally)
- Mental health and substance abuse services
- Maternity (pregnancy) and newborn care
- Pediatric services (health care for children)
- Durable medical equipment (Durable medical equipment or DME includes medical equipment and supplies for things like hospital beds, crutches, wheelchairs and oxygen tanks)

Take a closer look at prescription drug coverage

Prescription drug benefits help cover the cost of medications your doctor prescribes. We're here to help you better understand how our prescription drug plans work and the choices you have when it comes to selecting and paying for these medications. Always talk to your doctor first about which medication is right for you.

Select drug list (Drug formulary)

All of our prescription drug plans have a formulary, called the Select Drug List. The Select Drug List is not a complete list, but is simply a list of the most commonly used FDA-approved drugs that your plan covers.

Prescription drug tiers

Every drug on the Select Drug List is assigned to a certain tier (or level) based on cost, availability of over-the-counter alternatives, clinical information and certain drugs used to treat the same or similar condition. The drug list tells you what tier your drug is in and related details on coverage. What you pay for your prescription depends, in part, on which tier your drug is in. For example, Tier 1 usually includes preferred generic drugs with the lowest cost to you. As the tier number increases, the drugs in that tier generally cost you more. If your drug is in a higher tier, you may want to speak with your doctor to find out if one of the drugs covered in a lower tier will work for you.

You can save even more money with home delivery pharmacy

Anthem wants to help lower the cost of prescription drugs, improve overall health and deliver top-notch customer service. We're here to help you understand and manage medicines used to treat a wide variety of conditions.

If you take certain drugs on a regular basis (e.g. maintenance medicines), you have the choice to use our convenient home delivery pharmacy, managed by Express Scripts, Inc., or continue to get the medicines at a retail pharmacy. These drugs are used for conditions like high blood pressure and high cholesterol. Whatever you decide, you'll need to let Express Scripts know before your third refill of any medicine at a retail pharmacy. If you haven't by then, your prescriptions won't be covered until you call Express Scripts and notify them of your choice. So make sure you call them as soon as possible.

Home delivery is convenient and safe

- You get up to a 90-day supply for non-specialty drugs
- Drugs are delivered straight to your door — with free standard shipping
- You can order refills your way – online, using our mobile app, by phone or by mail
- Many safety and high-level quality checks help make sure you get the right medicine in the right dose

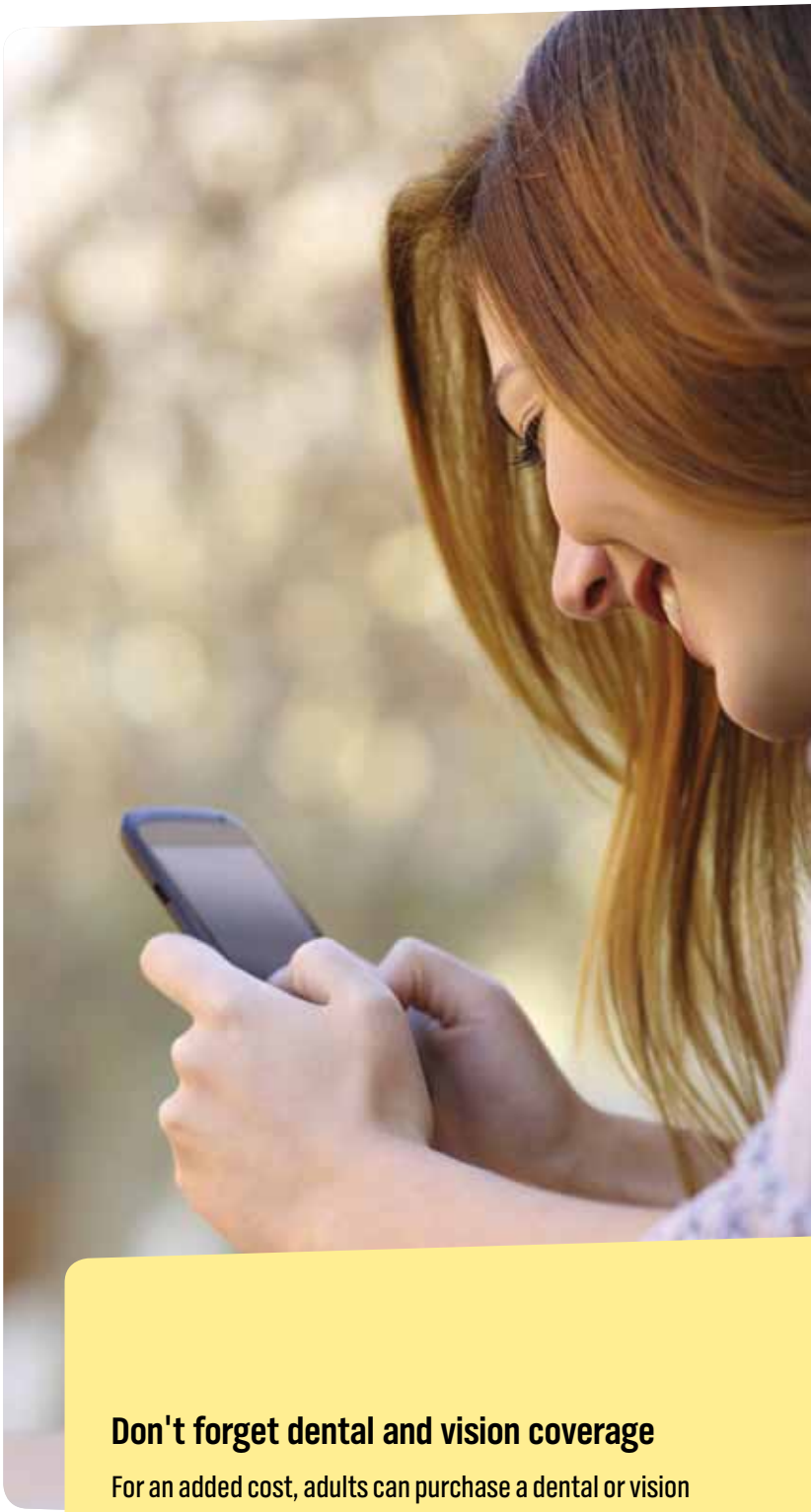
Manage your prescription drug benefits from your smartphone

Just by going to your health plan's mobile app, you can easily take advantage of our handy pharmacy tools on the go. With the click of a button you can:

- Locate a pharmacy
- Price a medication
- Switch from retail to home delivery
- Order a refill
- Check order status
- And more!

For more information, go to anthem.com/ca:

- To find out if your medication is covered, take a look at our drug list at www.anthem.com/ca/selectdrugtier4.
- To learn more about pharmacy processes (such as prior authorization, step therapy, quantity limits, dose optimization), check out the FAQs at Customer Support > FAQs > FAQ Categories > Pharmacy.
- To see if your pharmacy is in our network, visit our Find a Doctor tool.



Don't forget dental and vision coverage

For an added cost, adults can purchase a dental or vision plan from Anthem. Just call your Anthem Authorized Agent or go online to anthem.com/ca for details.

See a term you're not familiar with? Check out our Glossary in the back of this brochure.

Choose the doctors and hospitals you know and trust

At Anthem, our goal is to work with doctors, hospitals and other health care providers who will give you quality care at a fair cost. Our networks include:

- Doctors and hospitals
- Emergency and urgent care centers
- Labs
- Durable medical equipment (includes retail and online stores)
- Mental health providers

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

Anthem's preventive care coverage options give you access to any of our in-network doctors, so you pay nothing out of pocket. Stay in control of your health care and your finances with $0 deductible, $0 copay and $0 added cost to you for covered preventive services received in our network.[1]

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

Stay in control of quality and costs with our easy-to-use online tools

Anthem offers a range of ways to get the information you need. From our website to cost and quality comparison tools to our mobile app that lets you find a doctor from the palm of your hand, we help make sure you have everything you need to make the best health care decisions for you and your family. With our website, you can:

- Get an idea of what is and isn't covered by your plan with an easy-to-understand breakdown of your benefits summary.
- Get instant access to your recent claims and coverage details.
- Know your costs before having certain procedures with cost estimates using our out-of-pocket cost calculator.

Find a Doctor

Want to make sure your doctor is in our network? Need to find a new doctor or specialist? No problem! Our online Find a Doctor tool helps you find doctors, hospitals, pharmacies and other specialists in your area — and shows whether they are cost-saving network providers.

Log on to anthem.com/ca anytime or download our mobile app right to your phone, so you can search for doctors when you're on the go. When using the Find a Doctor tool, be sure to include the plan network as search criteria for the plan you are considering (Pathway PPO, Pathway HMO or Pathway Tiered (EPO), network availability depends on where you live).

LiveHealth Online

When you or a family member is feeling under the weather, life doesn't wait for you to feel better. Good news is, with LiveHealth Online, you get medical care right when you need it. No appointments, no driving and no waiting at an urgent care center.

LiveHealth Online lets you connect with a doctor through your mobile device or a computer with a webcam. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections and allergies. It's faster, easier and more convenient than a visit to an urgent care center. And it's even available while traveling as long as online doctor visits are offered in that state.[2]

LiveHealth Online gives you peace of mind with:

- Immediate access to your choice of doctors.
- Secure and private video chats with board-certified doctors.
- Prescriptions sent directly to your pharmacy, if needed.[3]

After you're an Anthem member, enroll — download the LiveHealth Online app or go to livehealthonline.com!

Vitals health survey

Vitals makes it easy for you to see what other patients have said about the doctors and hospitals you may be thinking about using. Hearing what other patients' experiences were like can help you make more informed health care decisions about your own care. You can also share your experience with others by reviewing your doctor online!

Cost and quality information with Estimate Your Cost

Save time and money by comparing the cost of common procedures at health care facilities in your area. You'll also get to compare quality and safety.

SpecialOffers discounts on health-related products and services

Enjoy members-only discounts on vitamins, health and beauty products, chiropractic care, acupuncture, massage therapy, LASIK eye surgery, eyeglass frames and contact lenses, hearing aids and services, fitness center memberships, Jenny Craig® and Weight Watchers® weight-loss programs and more. To view all discounts, log in at anthem.com/ca and click on Discounts located on the Main Overview page.

Register at anthem.com/ca for online access

Once you're a member, you'll want to register to get online access to your benefits. It's the information you need to make an informed decision – all in one place.

To register, type anthem.com/ca in the web browser address field and click **Register Now** on the top right-hand side of your screen in the member log in area.

Don't miss out on these great tools! Be sure to register at anthem.com/ca.

Take charge of your health with our health and wellness programs

Your health goals and needs are as unique as you are. That's why Anthem gives you access to programs that help you meet your personal goals and live your life to the fullest.

Get help from nurses 24/7

Day or night, you can talk to a registered nurse about your health concerns. Whether it's a question about allergies, the flu or choosing between the ER or urgent care, our nurses are there to give support. Going to the right place when you're not feeling well can save you time and money.

Supporting you when you have a larger health problem

Your health is our top priority. If you have a chronic or complex health problem, our Care Management Support program may be able to help. A case manager may call you to see how we can help you manage your health concerns. Our case managers can provide you with helpful information and offer emotional support services, if needed.

MyHealth Advantage

We're always looking for ways to help you live a healthier life and save money. That's why we review your medical and pharmacy history. If we find a way we think you can improve your health or save money, you'll get a MyHealth Note in the mail.

Coverage for emergency and urgent care – no matter where you are in the U.S. – with BlueCard®

When you're traveling for work or on vacation, going to the ER or urgent care is probably the last thing you want to happen. The good news is our plans cover emergency and urgent care in every state through the Blue Cross and Blue Shield Association's BlueCard® Program. This means you and your family have emergency and urgent care coverage from coast to coast.

Find the plan that's right for you

Choosing the right health care coverage is an important decision. Before you choose a plan, consider these tips. And remember, your Anthem Authorized Agent is here to answer any questions.

Plan ahead

- **Make sure the plan will meet your health care coverage needs**. Think about how often you see doctors and specialists. What prescription medications do you take regularly?
- **If staying with your current doctors is important**, see if they're in our network by using our online Find a Doctor tool at anthem.com/ca. Seeing in-network doctors can save you a lot of money on your health care.
- **Figure out your family's budget for coverage**. Some people would prefer to pay more in premium each month and less out of pocket each time for services like doctors' visits or lab work. Plans may offer different deductible, coinsurance and copay options so you can choose the level of cost sharing that meets your health care coverage needs and budget.
- **Review your plan options.** We offer plans to fit your health care coverage needs — and your budget. They are split into four different levels — Bronze, Silver, Gold and Platinum. Your costs and coverage increase with each level.
  - *Bronze* - With a Bronze plan, you pay less for your monthly premium but you pay more when you get care. You have broad benefits with deductibles, copays and coinsurance that may be higher than the other plans.
  - *Silver* - Silver plans still have low monthly premiums but you pay less when you get care. However, the monthly premium is higher than a Bronze plan.
  - *Gold* - With a Gold plan, you have richer benefits and pay less when you get care. However, the monthly premium is higher than the Bronze and Silver plans.
  - *Platinum* - You enjoy the highest level of benefits and often pay less when you get care. However, you pay the highest monthly premiums with a Platinum plan.
- **Consider making contributions to a Health Savings Account (HSA).** Making post-tax contributions to an HSA can help make your money go further. An HSA is a savings account that you can open when you have a qualified high deductible health plan (HDHP). You set up the account through a bank and fund it with post tax dollars. That money can be used to pay for your qualified health care expenses, including prescriptions. Talk to your financial advisor about potential tax advantages.

Explore your options if you need help paying for coverage

The Affordable Care Act requires you to have health care coverage unless you qualify for an exemption. In addition, you may qualify for premium tax credits to help lower the cost of your monthly premium. You may also qualify for cost-sharing subsidies on Silver plans purchased on Covered California, which can reduce the amount you pay for health care services. Or you may be eligible for Medi-Cal, California's Medicaid program. The amount and type of financial help you could receive is based on your income, family size and health care expenses where you live.

- **See if you qualify to get help paying for your health insurance.** Before you choose a plan, it's a good idea to find out if you qualify to get help paying for your health insurance. If you do qualify, it may make more sense for you to choose an Anthem plan available through Covered California. Whether you choose an Anthem plan offered through Covered California or direct through Anthem, we have great plan options for you.

When you can purchase a plan

Generally, plans can be purchased once a year through an open enrollment period. This year, the open enrollment period runs November 15, 2014 through February 15, 2015. The annual open enrollment period may vary from year to year, so you should check with your Anthem Authorized Agent for more information.

Not sure what something means? See the Glossary in the back of this brochure.

When certain events occur in life, you can enroll in a plan

There are a lot of life events — from having a baby to moving to a new state — that may allow you to change your health plan during a **special enrollment period**. These are called "qualifying events." If you've had a change in your coverage, family or income that qualifies, you can shop for a new health plan without waiting for the next open enrollment period.

Let us know if you're:

- Losing coverage at work
- Getting married or divorced
- Having a baby or adopting a child
- Turning 26 and no longer covered under your parents' plan
- Experiencing other changes in your coverage, family or income
- Moving soon or just moved

Don't wait too long. Most people have only 60 calendar days after a qualifying event to enroll in a new plan. You'll need to show proof of the qualifying event.

Check with your Anthem Authorized Agent for effective date options and guidelines around enrollment during other times of the year.

Avoid tax penalties

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

Ready to enroll in a plan? We can help!

Your Anthem Authorized Agent is available to make enrolling as easy as possible for you. You can also apply online at anthem.com/ca.

Follow these easy steps to enroll in one of our health plans

You and your family can receive all of the benefits of the Affordable Care Act. All you have to do is enroll. You may have heard it's hard to do, but it's really not and we're here to help you every step of the way.

What you'll need

Before you begin the enrollment process, be sure to have these handy:

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

How to enroll in one of our Anthem plans

- Call your Anthem Authorized Agent to enroll or learn more about the health care plans offered by Anthem.
- Visit our website at anthem.com/ca and apply online.

Save money by making smart choices

- ***Save money on prescriptions with home delivery*** **-** When you use our home delivery pharmacy instead of a retail pharmacy, you'll save on drugs you take on a regular basis for a long time (e.g., maintenance medicines). These drugs are used for conditions like high blood pressure and high cholesterol. You can usually get a 90-day supply of non-specialty drugs for less than you would at a retail pharmacy, and standard shipping is free.

- ***Save time and money with an urgent care center or retail health clinic*** - You may save money - and usually lots of time - by going to places other than the emergency room (ER) when you need care for something other than an emergency. If you need care - and you're certain it's not a real emergency - the Find a Doctor tool at anthem.com/ca can help find care alternatives to the ER like, urgent care centers, walk-in doctors' offices and retail health clinics.

- ***Using* in-network *doctors can help you save* -** When you need care, you will get the best value by visiting **in-network** doctors, hospitals or other health care providers. **In-network** (or participating) refers to doctors, hospitals and other health care providers that have agreed to accept lower negotiated rates (discounted prices) for their covered services. These agreed upon rates can help lower the cost of covered health care services, including your share of the costs. This is true when you're paying the whole cost for covered services (such as while you are meeting your deductible). And it's also true when we are sharing the cost (while you are meeting your out-of-pocket limit).

  Out-of-network (or nonparticipating) refers to doctors, hospitals and other health care providers that are not contracted with Anthem to provide services at a negotiated rate. **Our health maintenance organization (Pathway HMO) and Tiered (exclusive provider organization (Pathway Tiered (EPO)) plans do not offer out-of-network benefits (with the exception of emergency and urgent care or when we authorize care)**. This means you will pay the entire cost for any service you get from **out-of-network** providers. **With our preferred provider organization (Pathway PPO) plans, you have the choice to visit out-of-network doctors or hospitals, but your share of the costs may be greater.**

  To find out if your current health care provider is in our network, visit our Find a Doctor tool on anthem.com/ca.

- ***The doctors you can see* -** With our **Pathway PPO** and **Pathway Tiered (EPO)** plans, you have the freedom to see any in-network doctor you choose. It's also a good idea to have a primary care physician (PCP) for things like checkups and health issues that need ongoing care. However, you're not required to pick one.

  With our **Pathway HMO** plan, you choose one of our in-network PCPs who helps to coordinate your care. When you want to see other doctors, you may need to get a referral from your primary care doctor.

  Please refer to the Benefit Snapshot included with this brochure for information on plan availability in your area.

- ***Tiered networks* –** Our EPO plans include a tiered network. In-network hospitals are split into two categories, Tier 1 and Tier 2. You'll pay a lower cost share for hospitals in Tier 1.

Not sure what something means? See the Glossary in the back of this brochure.

Helping you understand how your health care plan works

Health care coverage can help protect you against the high costs of care. With most health care coverage, you pay a monthly fee called a premium; then, you share some of the cost of covered care with the company that provides your coverage. With Anthem, you can choose the level of cost sharing that works best for your health care needs and budget.

Here's an example: *Meet John*

John's story is only an example of how health plans work. John is not a real person and the example below is for illustrative purposes only. Be sure to look at the benefits for each of our plan choices for specific information.

John's health plan has the following benefits:

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

After injuring his knee in a soccer game, John calls his doctor. He chooses providers in our network, which saves him the most money. By choosing providers in our network, John gets lower negotiated rates (meaning, discounted prices). In the following examples, you'll see what John paid and why it's important to have health insurance.

Copay (Copayment)

On some plans you pay a fixed dollar amount for certain services when you get them. For example, when you see a doctor, you may be asked to pay a $35 copay.

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

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

Deductible

You pay this amount for covered medical services each calendar year which means January 1 through December 31. Covered services that apply to the deductible may include lab work, X-rays, anesthesia and surgeon fees. (Covered preventive services start before the deductible is met.) Your deductible starts over each calendar year.

Please note:
For most of our plans, each family member has an individual deductible and out-of-pocket limit. The family deductible and out-of-pocket limit can be satisfied by two or more members. No one person can contribute more than his or her individual deductible or out-of-pocket limit.

Here's what happens next when John's doctor orders an approved MRI of the knee and recommends surgery:

MRI

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

Surgery

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

Coinsurance

Once you've met your deductible, Anthem starts paying a portion of claims. The health care bills that remain are shared between you and Anthem. Your coinsurance is the percent that you must pay for a covered service per calendar year. Having met his deductible, John's coinsurance begins.

Let's check in to see what John will be paying.

- ***Coinsurance:*** 30% (30% of $34,000 = $10,200)
- *What John paid:* $2,965 (John's payment satisfies the remainder of his $5,000 out-of-pocket limit.)

Out-of-pocket limit

The most you pay during a policy period before your health insurance begins to pay at 100% (of the maximum allowed amount). The amounts you pay for your deductible, coinsurance and copay are typically what make up your out-of-pocket limit. Once you meet your out-of-pocket limit, we pay 100% (of the maximum allowed amount) of covered services for the rest of the calendar year.

John has met his out-of-pocket limit and the remaining surgery costs are paid by Anthem.

- Anthem ***pays:*** $31,035
- ***Out-of-pocket limit:*** $5,000 (John paid: $35 copay for doctor office visit + $2,000 deductible + $2,965 coinsurance)

Summary

John paid far less out-of-pocket because he had health care coverage. If John had used a provider outside of our network, depending on his plan, he might not have had coverage or would have had to pay much more.

- ***Total for doctor visit, MRI and surgery (without health insurance):*** $51,700
- ***Total*** Anthem ***paid after discounts:*** $31,140
- *Total John paid:* $5,000

Glossary

Affordable Care Act (also known as health care reform)
The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

BlueCard
BlueCard is a national program that lets members of one Blue Cross and Blue Shield (BCBS) plan access health care services while traveling in another BCBS plan's service area. Available services may be limited with these plans. To find doctors and hospital in the BlueCard program, have your ID card handy and visit the BlueCard Doctor and Hospital Finder at bcbs.com.

Brand-name drugs
These are drugs that are developed by a company that holds the patents and rights to sell them.

Coinsurance
The amount that you pay for health care services. This is usually a certain percentage of the cost of health care services after the deductible has been paid. *Example*: A health plan pays 80% of the maximum allowed amount for the service and you pay the remaining 20%. This is referred to as the coinsurance.

Copay (also copayment)
A fixed fee that you pay out-of-pocket for each visit to a health care provider. For example, if your copayment is $30, then you pay $30 when you see your doctor — usually at the time you receive treatment. The amount of your copayment sometimes varies by the type of health care service you receive.

Deductible
This is a set amount that you pay before your plan starts paying for covered services. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. Some plans may cover certain services, such as doctor's office visits, before you meet the deductible. Note: You must meet your deductible every calendar year even if your effective date (the date your coverage begins) is later than January 1. The calendar year runs from January 1 through December 31.

Exchange (also known as the Marketplace)
A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan and enroll in coverage. The name of the Exchange in your state is Covered California.

Exclusions
Exclusions are health care goods and services that are not covered by your health plan. You can find a list of exclusions in your plan materials.

Formulary (also Select Drug List)
This is a list of the most commonly used drugs your plan covers. The list tells you what tier your drug is in and related details on coverage.

Generic drugs
Generics are copies of brand-name drugs with the same active ingredients. Most generics usually cost you less money than their brand-name counterparts.

Health Savings Account (HSA)
A HSA is a savings account that you can open when you have a qualified high deductible health plan (HDHP). You set up the account through a bank and fund it with post tax dollars. That money can be used to pay for your qualified health care expenses, including prescriptions.

High-deductible health plan (HDHP)
A HDHP has lower premiums and higher deductibles than a traditional health plan.

In-network/Network
Refers to providers who participate in the plan's network.

Out-of-network/Non-network
Refers to providers who do not participate in the plan's network.

Out-of-pocket limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the maximum allowed amount. This limit never includes your premium, balance-billed charges, or health care your insurance or plan doesn't cover.

Premium
The amount that must be paid for your health insurance or plan. You usually pay it monthly, quarterly or yearly.

Premium tax credit
A fixed amount or percentage of a member's premium provided as a tax credit to help low-income individuals buy health insurance on the Exchange. You can use it to buy any plan offered on the Exchange in your state.

Prescription drug tiers
Every drug on the formulary (Select Drug List) is in a cost-sharing tier. The tier level determines what you will pay for your prescription.

Primary Care Physicians (PCPs)
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Provider
A doctor, hospital, licensed health care facility, program, agency or health care professional that delivers health care services.

Subsidy (also cost-sharing subsidy/reductions)

An extra cost reduction available to low-income individuals who buy a Silver plan on the Exchange. Cost-sharing subsidies lower the deductible, copay and other out-of-pocket charges that you pay when you use your health plan. If you're eligible for cost-sharing reductions and enroll in a Silver plan, you'll automatically receive a cost-share reduction version of the plan.

Learn more

You've read about a lot in this brochure. If you'd like to learn even more, here is a list of helpful resources:

- ***Health care reform hub***
  makinghealthcarereformwork.com (visit anthem.com/ca > Resources > select Health Care Reform)
- ***Subsidy Estimator***
  https://www.affordableca.com/covered-california-premium-subsidy-calculator/
- ***www.coveredca.com***
- ***Will I qualify to save on monthly premiums?***
  www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums/
- ***Injury Facts 2011 Edition***, National Safety Council
  nsc.org/news_resources/injury_and_death_statistics/Documents/Injury-Facts-Report.pdf
- ***The Unsustainable Cost of Health Care***
  Social Security Advisory Board ssab.gov/Documents/Summary-HealthCare.pdf
- ***The Henry J. Kaiser Family Foundation***
  statehealthfacts.org
- ***National Hospital Discharge Survey***
  Centers for Disease Control and Prevention
  cdc.gov/nchs/nhds.htm
- ***Costhelper***
  health.costhelper.com/broken-leg.html

Anthem BlueCross

Get help today!

Call your Anthem Authorized Agent or visit us online at anthem.com/ca where you can view and compare plan options.

We want you to be satisfied

After you enroll in a plan offered by Anthem, you'll receive an Agreement that explains the exact terms and conditions of coverage, including the Agreement's exclusions and limitations. You will have 10 days to examine your Agreement's features. During that time, if you are not fully satisfied, you may cancel your Agreement and your premium will be refunded, less 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, including what's covered and what isn't:

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

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

The health plans described within this document are not eligible for a premium tax credit/subsidy or cost-sharing assistance.

Health care reform, or the Affordable Care Act (ACA), lets people with low or modest incomes use a premium tax credit or subsidy to help pay for their health insurance. You can only get financial help if you are eligible and buy your individual health coverage through Covered California.

In accordance with the Affordable Care Act, benefits, formularies, pharmacy and provider networks, premiums and copayments/coinsurance for these plans may change on January 1 of each year.

The following plans are issued by Anthem Blue Cross : Anthem Bronze Pathway PPO plans 5000/25%, 5750/20% and 6250/20%; Anthem Bronze Pathway EPO plans 5000/25%, 5750/20% and 6250/20%; Anthem Bronze plans 60 D PPO, 60 D HSA PPO, 60 D EPO and 60 D HSA EPO; Anthem Silver Pathway PPO plans 1750/30% and 2000/25%; Anthem Silver Pathway EPO plans 1750/30% and 2000/25%; Anthem Silver plans 70 D PPO, 70 D EPO and 70 D HMO; Anthem Gold plans 80 D PPO, 80 D EPO and 80 D HMO; Anthem Platinum plans 90 D PPO, 90 D EPO and 90 D HMO; and Anthem Minimum Coverage plans D PPO and D EPO.

1. Nationally recommended preventive care services received from in-network providers have no copay and no deductible requirement. Preventive and wellness services consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.
2. LiveHealth Online is offered in most states and is expected to grow more in the near future. Visit the home page at livehealthonline.com to see the latest map showing where service is available.
3. As legally permitted in certain states.

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. BenefitWallet is an independent corporate entity that provides banking administration on behalf of Anthem Blue Cross .

Individual and family health benefit plans for California

Benefit Snapshot

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

Pathway HMO and Pathway Tiered (EPO) Networks serving Los Angeles (North), Los Angeles (South), Orange and San Diego counties. Plans issued by Anthem Blue Cross.
Important: HMO plans are not available in all zip codes within some counties. Please see the list of excluded zip codes on the Notes page of this Benefit Snapshot.

03619CAMENABC Rev. 2/15

Benefit Snapshot

Anthem Blue Cross (Anthem) is pleased to offer individual plan choices. Below is a listing of them, including a sample of commonly used benefits and how they're covered under each plan. ***Cost-share and benefit information in this snapshot is for in-network covered services unless otherwise noted.*** When filling out an application, be sure the entire plan name on the application matches the plan you're applying for.

Our plan names include the following elements: Anthem + metal level + network name + deductible/coinsurance + (HSA) or Anthem + metal level + ## + D + product type + (HSA) (Example: Anthem Bronze Pathway EPO 5000/25% or Anthem Silver 70 D HMO). If you need more information about a benefit that is not listed here, please check with your Anthem Authorized Agent. You can also view and compare plans on anthem.com/ca.

	Anthem Bronze Pathway EPO 5000/25% (1FZK)	Anthem Bronze Pathway EPO 5750/20% (1FZJ)	Anthem Bronze Pathway EPO 6250/20% (1FZ8)	Anthem Bronze 60 D EPO (1FZ7)
Network Name[1]	Pathway Tiered (EPO)	Pathway Tiered (EPO)	Pathway Tiered (EPO)	Pathway Tiered (EPO)
Plan includes out-of-network coverage?[2]	No	No	No	No
Individual Deductible *(Family[3] = 2 x Individual amount)*	$5,000	$5,750	$6,250	$5,000
Individual Out-of-pocket Limit *(Includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)*	$6,450	$6,600	$6,600	$6,250
Coinsurance	25% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance
Office Visit: Primary Care Physician *(PCP)* *(includes post natal visits)* NOTE: Other office services subject to deductible and plan coinsurance.	Deductible, then 25% coinsurance	First 2 office visits: $50 copay, deductible waived 3+ office visits: Deductible, then 20% coinsurance	$40 copay, unlimited	First 3 office visits: $60 copay, deductible waived 4+ office visits: Deductible, then $60 copay
Office Visit: Specialist	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then $70 copay
Outpatient Diagnostic Tests *(Examples: X-ray, EKG)*	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Outpatient Advanced Diagnostic Tests *(Examples: MRI, CT scan)*	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Preventive Care[4]	No additional cost to you	No additional cost to you	No additional cost to you	No additional cost to you
Urgent Care	Deductible, then $50 copay and 25% coinsurance	Deductible, then $50 copay and 20% coinsurance	Deductible, then $50 copay and 20% coinsurance	First 3 visits: $120 copay, deductible waived 4+ office visits: Deductible, then $120 copay
Emergency Room Care *(Copay is waived if admitted into the Hospital from the Emergency Room)*	Deductible, then $200 copay and 25% coinsurance	Deductible, then $350 copay and 20% coinsurance	Deductible, then $250 copay and 20% coinsurance	Deductible, then $300 copay
Hospital: Inpatient Admission[5] *(e.g. hospital room)(includes maternity, mental health and substance abuse)*	Deductible, then 25% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 40% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance
Hospital: Outpatient Surgery Hospital Facility[5] *(includes maternity, mental health and substance abuse)*	Deductible, then 25% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 40% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance
Retail Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible	Combined with medical deductible
Retail Pharmacy Tier 1[6]	25% coinsurance	20% coinsurance	$19 copay	$15 copay
Retail Pharmacy Tier 2[6]	25% coinsurance	20% coinsurance	$50 copay	$50 copay
Retail Pharmacy Tier 3[6]	25% coinsurance	20% coinsurance	20% coinsurance	$75 copay
Retail Pharmacy Tier 4[6]	25% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance
Dental and Vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered

More about our plans...

[1]**Tiered hospitals:** This is a Tiered network plan. In-network hospitals are split into two categories, Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1.

[2]These plans do not include coverage for out-of-network benefits (with the exception of emergency and urgent care).

[3]Most of 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, prior to receiving plan benefits.

[4]Nationally recommended **preventive care services** received from in-network providers have no copay and no deductible requirement. **Preventive care services** consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

[5]Cost share shows Tier 1 / Tier 2 coinsurance for hospitals in our network.

[6]**Prescription drugs:** If you take certain drugs on a regular basis (e.g. maintenance medicines), you have the choice to use our convenient home delivery pharmacy, managed by Express Scripts, Inc., or continue to get the medicines at a retail pharmacy. Whatever you decide, you'll need to let Express Scripts know before your third refill of any medicine at a retail pharmacy. If you haven't by then, your prescriptions won't be covered until you call Express Scripts and notify them of your choice. So make sure you call them as soon as possible.

	Anthem Bronze 60 D HSA EPO (1FZN)	Anthem Silver Pathway EPO 1750/30% (1GOJ)	Anthem Silver Pathway EPO 2000/25% (1FZA)	Anthem Silver 70 D EPO (1FZS)
Network Name[1]	Pathway Tiered (EPO)	Pathway Tiered (EPO)	Pathway Tiered (EPO)	Pathway Tiered (EPO)
Plan includes out-of-network coverage?[2]	No	No	No	No
Individual Deductible *(Family[3] = 2 x Individual amount)*	$4,500	$1,750	$2,000	$2,000
Individual Out-of-pocket Limit *(Includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)*	$6,250	$6,350	$6,350	$6,250
Coinsurance	40% coinsurance	30% coinsurance	25% coinsurance	20% coinsurance
Office Visit: Primary Care Physician *(PCP)* *(includes post natal visits)* NOTE: Other office services subject to deductible and plan coinsurance.	Deductible, then 40% coinsurance	First 2 office visits: $35 copay, deductible waived 3+ office visits: Deductible, then 30% coinsurance	First 3 office visits: $35 copay, deductible waived 4+ office visits: Deductible, then 25% coinsurance	$45 copay, unlimited
Office Visit: Specialist	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 25% coinsurance	$65 copay, unlimited
Outpatient Diagnostic Tests *(Examples: X-ray, EKG)*	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 25% coinsurance	$65 copay, not subject to deductible
Outpatient Advanced Diagnostic Tests *(Examples: MRI, CT scan)*	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance
Preventive Care[4]	No additional cost to you	No additional cost to you	No additional cost to you	No additional cost to you
Urgent Care	Deductible, then 40% coinsurance	Deductible, then $50 copay and 30% coinsurance	Deductible, then $50 copay and 25% coinsurance	$90 copay, not subject to deductible
Emergency Room Care *(Copay is waived if admitted into the Hospital from the Emergency Room)*	Deductible, then 40% coinsurance	Deductible, then $200 copay and 30% coinsurance	Deductible, then $200 copay and 25% coinsurance	Deductible, then $250 copay
Hospital: Inpatient Admission[5] *(e.g. hospital room)(includes maternity, mental health and substance abuse)*	Deductible, then 40% (tier 1) / 60% (tier 2) coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 25% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance
Hospital: Outpatient Surgery Hospital Facility[5] *(includes maternity, mental health and substance abuse)*	Deductible, then 40% (tier 1) / 60% (tier 2) coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 25% (tier 1) / 50% (tier 2) coinsurance	20% (tier 1) / 50% (tier 2) coinsurance, not subject to deductible
Retail Pharmacy Deductible	Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible	Combined with medical deductible	Tier 1: No deductible Tiers 2, 3, 4: $250 combined pharmacy deductible
Retail Pharmacy Tier 1[6]	40% coinsurance	$19 copay	25% coinsurance	$15 copay
Retail Pharmacy Tier 2[6]	40% coinsurance	$40 copay	25% coinsurance	$50 copay
Retail Pharmacy Tier 3[6]	40% coinsurance	30% coinsurance	25% coinsurance	$70 copay
Retail Pharmacy Tier 4[6]	40% coinsurance	30% coinsurance	25% coinsurance	20% coinsurance
Dental and Vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered

More about our plans...

[1]**Tiered hospitals:** This is a Tiered network plan. In-network hospitals are split into two categories, Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1.

[2]These plans do not include coverage for out-of-network benefits (with the exception of emergency and urgent care).

[3]Most of 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, prior to receiving plan benefits.

[4]Nationally recommended **preventive care services** received from in-network providers have no copay and no deductible requirement. **Preventive care services** consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

[5]Cost share shows Tier 1 / Tier 2 coinsurance for hospitals in our network.

[6]**Prescription drugs:** If you take certain drugs on a regular basis (e.g. maintenance medicines), you have the choice to use our convenient home delivery pharmacy, managed by Express Scripts, Inc., or continue to get the medicines at a retail pharmacy. Whatever you decide, you'll need to let Express Scripts know before your third refill of any medicine at a retail pharmacy. If you haven't by then, your prescriptions won't be covered until you call Express Scripts and notify them of your choice. So make sure you call them as soon as possible.

	Anthem Silver 70 D HMO (1G02)	Anthem Gold 80 D EPO (1G07)	Anthem Gold 80 D HMO (1G0B)	Anthem Platinum 90 D EPO (1G0D)
Network Name[1]	Pathway HMO	Pathway Tiered (EPO)	Pathway HMO	Pathway Tiered (EPO)
Plan includes out-of-network coverage?[2]	No	No	No	No
Individual Deductible *(Family[3] = 2 x Individual amount)*	$2,000	$0	$0	$0
Individual Out-of-pocket Limit *(Includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)*	$6,250	$6,250	$6,250	$4,000
Coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	10% coinsurance
Office Visit: Primary Care Physician *(PCP)* *(includes post natal visits)* NOTE: Other office services subject to deductible and plan coinsurance.	$45 copay, unlimited	$30 copay, unlimited	$30 copay, unlimited	$20 copay, unlimited
Office Visit: Specialist	$65 copay, unlimited	$50 copay, unlimited	$50 copay, unlimited	$40 copay, unlimited
Outpatient Diagnostic Tests *(Examples: X-ray, EKG)*	$65 copay, not subject to deductible	$50 copay	$50 copay	$40 copay
Outpatient Advanced Diagnostic Tests *(Examples: MRI, CT scan)*	$250 copay, not subject to deductible	20% coinsurance	$250 copay	10% coinsurance
Preventive Care[4]	No additional cost to you	No additional cost to you	No additional cost to you	No additional cost to you
Urgent Care	$90 copay, not subject to deductible	$60 copay	$60 copay	$40 copay
Emergency Room Care *(Copay is waived if admitted into the Hospital from the Emergency Room)*	Deductible, then $250 copay	$250 copay	$250 copay	$150 copay
Hospital: Inpatient Admission[5] *(e.g. hospital room)(includes maternity, mental health and substance abuse)*	Deductible, then 20% coinsurance	20% (tier 1) / 50% (tier 2) coinsurance	$600 copay per day up to 5 days	10% (tier 1) / 40% (tier 2) coinsurance
Hospital: Outpatient Surgery Hospital Facility[5] *(includes maternity, mental health and substance abuse)*	20% coinsurance, not subject to deductible	20% (tier 1) / 50% (tier 2) coinsurance	$600 copay	10% (tier 1) / 40% (tier 2) coinsurance
Retail Pharmacy Deductible	Tier 1: No deductible Tiers 2, 3, 4: $250 combined pharmacy deductible	No deductible	No deductible	No deductible
Retail Pharmacy Tier 1[6]	$15 copay	$15 copay	$15 copay	$5 copay
Retail Pharmacy Tier 2[6]	$50 copay	$50 copay	$50 copay	$15 copay
Retail Pharmacy Tier 3[6]	$70 copay	$70 copay	$70 copay	$25 copay
Retail Pharmacy Tier 4[6]	20% coinsurance	20% coinsurance	20% coinsurance	10% coinsurance
Dental and Vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered

More about our plans...

[1]**Tiered hospitals:** This is a Tiered network plan. In-network hospitals are split into two categories, Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1.

[2]These plans do not include coverage for out-of-network benefits (with the exception of emergency and urgent care).

[3]Most of 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, prior to receiving plan benefits.

[4]Nationally recommended **preventive care services** received from in-network providers have no copay and no deductible requirement. **Preventive care services** consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

[5]Cost share shows Tier 1 / Tier 2 coinsurance for hospitals in our network.

[6]**Prescription drugs:** If you take certain drugs on a regular basis (e.g. maintenance medicines), you have the choice to use our convenient home delivery pharmacy, managed by Express Scripts, Inc., or continue to get the medicines at a retail pharmacy. Whatever you decide, you'll need to let Express Scripts know before your third refill of any medicine at a retail pharmacy. If you haven't by then, your prescriptions won't be covered until you call Express Scripts and notify them of your choice. So make sure you call them as soon as possible.

	Anthem Platinum 90 D HMO (1GOH)
Network Name[1]	Pathway HMO
Plan includes out-of-network coverage?[2]	No
Individual Deductible *(Family[3] = 2 x Individual amount)*	$0
Individual Out-of-pocket Limit *(Includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)*	$4,000
Coinsurance	10% coinsurance
Office Visit: Primary Care Physician *(PCP)* *(includes post natal visits)* NOTE: Other office services subject to deductible and plan coinsurance.	$20 copay, unlimited
Office Visit: Specialist	$40 copay, unlimited
Outpatient Diagnostic Tests *(Examples: X-ray, EKG)*	$40 copay
Outpatient Advanced Diagnostic Tests *(Examples: MRI, CT scan)*	$150 copay
Preventive Care[4]	No additional cost to you
Urgent Care	$40 copay
Emergency Room Care *(Copay is waived if admitted into the Hospital from the Emergency Room)*	$150 copay
Hospital: Inpatient Admission[5] *(e.g. hospital room)(includes maternity, mental health and substance abuse)*	$250 per day up to 5 days
Hospital: Outpatient Surgery Hospital Facility[5] *(includes maternity, mental health and substance abuse)*	$250 copay
Retail Pharmacy Deductible	No deductible
Retail Pharmacy Tier 1[6]	$5 copay
Retail Pharmacy Tier 2[6]	$15 copay
Retail Pharmacy Tier 3[6]	$25 copay
Retail Pharmacy Tier 4[6]	10% coinsurance
Dental and Vision	Pediatric dental and vision covered Adult dental and vision not covered

More about our plans...

[1]**Tiered hospitals:** This is a Tiered network plan. In-network hospitals are split into two categories, Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1.

[2]These plans do not include coverage for out-of-network benefits (with the exception of emergency and urgent care).

[3]Most of 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, prior to receiving plan benefits.

[4]Nationally recommended **preventive care services** received from in-network providers have no copay and no deductible requirement. **Preventive care services** consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

[5]Cost share shows Tier 1 / Tier 2 coinsurance for hospitals in our network.

[6]**Prescription drugs:** If you take certain drugs on a regular basis (e.g. maintenance medicines), you have the choice to use our convenient home delivery pharmacy, managed by Express Scripts, Inc., or continue to get the medicines at a retail pharmacy. Whatever you decide, you'll need to let Express Scripts know before your third refill of any medicine at a retail pharmacy. If you haven't by then, your prescriptions won't be covered until you call Express Scripts and notify them of your choice. So make sure you call them as soon as possible.

Notes

Pathway Tiered (EPO): An exclusive provider organization (EPO) plan is a type of managed care plan. The EPO network is made up of a select group of care providers. With the exception of an emergency situation, you will only get benefits from an in-network provider if your plan is part of this network. With these plans, you can see an in-network specialist without a referral from your primary care physician.

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

HMO plans not offered in these zip codes:
Los Angeles: 90313, 90397, 90398, 90612, 90623, 90630, 90631, 90659, 90704, 90822, 90845, 90888, 91131, 91191, 91310, 91354, 91363, 91383, 91384, 91390, 91399, 91497, 91709, 91797, 91799, 91841, 93243, 93532, 93544
San Diego: 91905, 91906, 91916, 91934, 91948, 91962, 91963, 91980, 91987, 91990, 92004, 92066, 92070, 92086, 92090, 92133, 92194

Notes

Get help today!

Call your Anthem Authorized Agent or visit us online at anthem.com/ca where you can view and compare plan options.

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, including what's covered and what isn't:

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

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

The health plans described within this document are not eligible for a premium tax credit/subsidy or cost-sharing assistance. Health care reform, or the Affordable Care Act (ACA), lets people with low or modest incomes use a premium tax credit or subsidy to help pay for their health insurance. You can only get financial help if you are eligible and you buy your individual health coverage through Covered California.

In accordance with the Affordable Care Act, benefits, formularies, pharmacy and provider networks, premiums and copayments/coinsurance for these plans may change on January 1 of each year.

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

Your HSA: Convenience, savings and flexibility all rolled into one

Introducing BenefitWallet:

Setting up a Health Savings Account (HSA)

To realize your plan's full financial power, consider selecting a plan with an HSA account. The portability and tax savings of an HSA account can add up fast.

We've joined with BenefitWallet®, A Xerox Solution, to integrate its HSA Solution into a selection of our plans. Setting up your account with BenefitWallet is easy. Plus, 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 special checks and automatic fund transfers
- Competitive interest rates and investment opportunities for the funds in your account
- Mobile App for iPhone®, iPad® and AndroidTM devices and mobile access from any mobile device
- 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)

Of course, if you'd rather use another financial institution for your account, that's fine, too.

You're only one checkmark away

Simply make the selection on your application form. We'll take care of setting up your account. We'll also take care of sending you a *Welcome Kit* to get you started. All you have to take care of is your health. Which is, after all, the most important thing.

A closer look

HSA Welcome Kit

If you make the selection on your application form, your HSA will automatically be set up — no set-up fee required, and you'll soon receive an HSA Welcome Kit. In it, you'll find all of the banking documentation and instructions for using and opening 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 families. Once you're ready to invest, login 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, for more information or to begin investing.

Debit cards, checkbooks and online banking

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

Deposits to your account

To contribute to your HSA, simply 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. Or, you can set up an electronic funds transfer between your bank and BenefitWallet for one-time or recurring account contributions.

Account activity statements

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. For an additional fee of $1.25 per month, you can receive a paper statement. Please go to 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 in your HSA Welcome Kit. 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, 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.**

Coverage Details for California

Things you should know before you buy these plans...

Anthem Bronze Pathway PPO plans 5000/25%, 5750/20% and 6250/20%; Anthem Bronze Pathway EPO plans 5000/25%, 5750/20% and 6250/20%; Anthem Bronze plans 60 D PPO, 60 D HSA PPO; 60 D EPO and 60 D HSA EPO; Anthem Silver Pathway PPO plans 1750/30% and 2000/25%; Anthem Silver Pathway EPO plans 1750/30% and 2000/25%; Anthem Silver plans 70 D PPO, 70 D EPO and 70 D HMO; Anthem Gold plans 80 D PPO, 80 D EPO and 80 D HMO; Anthem Platinum plans 90 D PPO, 90 D EPO and 90 D HMO; and Anthem Minimum Coverage plans D PPO and D EPO

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

Open Enrollment

An annual open enrollment period is provided for enrollees in compliance with state and federal requirements. Individuals may enroll in a Plan and members may change their Agreement at that time.

Effective dates for annual open enrollment period:

The earliest effective date is the first day of the following benefit period. The actual effective date is determined by the date Anthem receives a complete application with the applicable premium payment.

If payment is received between the 1st through 15th of the month, the effective date is the first of the next month. If payment is received between the 16th through end of the month, the effective date is the first of the month after the next month.

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.

Effective dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2. In the case of marriage, domestic partnership or in the case where an individual loses minimum essential coverage, coverage is effective on the first day of the following month after your application is received.
3. For other qualifying events, when the application is received between the first day and the fifteenth day of the month, the effective date is the first day of the following month. When the application is received between the sixteenth day and last day of the month, the effective date is the first day of the second following month.

You must elect coverage and notify us within sixty (60) days.

Effective dates for special enrollment due to loss of minimum essential coverage apply when the loss of minimum essential coverage includes loss of eligibility for coverage as a result of:

1. Legal separation, dissolution of domestic partnership or divorce;
2. Cessation of dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the following:
    - Individual who no longer resides, lives or works in the Plan's service area,
    - A situation in which the Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

There is no special enrollment for loss of minimum essential coverage when the loss includes termination or loss due to:

1. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Preferred Provider Organization

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

In-network providers have an agreement in effect with Anthem and have agreed to accept the maximum allowed amount as payment in full. Out-of-network providers do not have an agreement with Anthem. Your personal financial costs when using out-of-network providers may be considerably higher than when you use in-network hospitals or in-network providers. Further, for certain services there may be no benefit provided when using an out-of-network provider. You will be responsible for any amount not paid by Anthem when using the services of an out-of-network provider.

Please refer to the Summary of Benefits carefully to determine these differences. For assistance locating in-network providers, you may contact us at **855-634-3381**;or access our website at anthem.com/ca. 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.

Choice of Preferred In-network Facililty, In-network Provider or Out-of-network Provider

With our PPO plans, you have the right to choose a preferred in-network facility,in-network provider or out-of-network provider as stated above. Choosing an out-of-network provider may impact your personal financial costs. Refer to the Summary of Benefits and the part "What is Covered - Medical" to review copayment and coinsurance differences between these types of providers since your responsibility is often significantly higher when you use an out-of-network provider.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Agreement and that you or your family member might need:

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

You should obtain more information before you become a subscriber or select an in-network provider. Call your prospective doctor or clinic; or call Anthem at **855-634-3381** to ensure that you can obtain the health care services that you need.

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

To see a doctor or provider, call their office:

- Tell them you are an Anthem member.
- Have your Member Identification Card handy. The doctor's office may ask for your group or ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Care with you.

Not all counties have this type of network available. Please refer to the end of this document for a list of counties where this network is available.

Exclusive Provider Organization (Tiered)

An exclusive provider organization (EPO) plan is a type of managed care plan. The EPO network is made up of a select group of care providers. With the exception of an emergency situation, you will only get benefits from an in-network provider if your plan is part of this network. With these plans, you can see an in-network specialist without a referral from your primary care physician.

Not all counties have this type of network available. Please refer to the end of this document for a list of counties where this network is available.

Health Maintenance Organization

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

Not all counties have this type of network available. Please refer to the end of this document for a list of counties where this network is available.

How to Find a Provider in the Network

There are three ways you can find out if a provider or facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

1. See your Plan's directory of in-network providers at anthem.com/ca, which lists the doctors, providers, and facilities that participate in this Plan's network.
2. Call Customer Service to ask for a list of doctors and providers that participate in this Plan's network, based on specialty and geographic area.
3. Check with your doctor or provider.

If you need help finding a doctor in our network, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Note: We have several provider networks, and a provider that is in our network for one Plan may not be in the network for another. Be sure to call Customer Service to find out which network your Plan will use.

Managing your care if you need to go to a hospital or get certain medical treatment

If you or a family member needs certain types of medical care (for example: surgery, treatment in a doctor's office, physical therapy, etc.), you may want to know more about these programs and terms. They may help you better understand your benefits and how your health plan manages these types of care.

Utilization Management

Utilization management (UM) is a program that is part of your health plan. It lets us make sure you're getting the right care at the right time. Our UM review team, made up of licensed health care professionals such as nurses and doctors, does medical reviews. The team goes over the information your doctor has sent us to see if the requested surgery, treatment or other type of care is medically needed. The UM review team checks to make sure the treatment meets certain rules set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The UM review team will let you and your doctor know as soon as possible.

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

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

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

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

The concurrent review (done during medical care and recovery)

We do a concurrent review when you are in the hospital or are released and need more care related to the hospital stay. This could mean services or treatment in a doctor's office, regular office visits, physical therapy or mental health therapy, home health care, durable medical equipment, a stay in a nursing home, mental health care visits and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.

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

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

Case Management

Case managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Preauthorization

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

Here's how getting preauthorization can help you out:

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

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

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

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:

- Artificial insemination, fertilization, infertility drugs or sterilization reversal
- Artificial and mechanical hearts
- Benefits covered by Medicare or a governmental program
- Breast reduction or augmentation
- 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)
- Chiropractic services
- Comfort and/or convenience items
- Cosmetic surgery and/or treatment that's primarily intended to improve your appearance
- Custodial care
- Dental, except as described in the Agreement
- Educational services
- Experimental or investigative treatment
- Health club memberships and fitness services
- Infertility testing and treatment
- Nutritional and dietary supplements
- Over-the-counter drugs, devices or products, except as mandated
- Pharmacy, except as described in the Agreement
- Private duty nursing
- Routine foot care
- Sclerotherapy (a medical procedure used to eliminate varicose veins and spider veins)
- Services we determine aren't medically necessary
- Vision, except as described in the Agreement
- Weight loss programs or treatment of obesity, except as mandated
- Workers' compensation

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

Summary of Networks by County

Pathway PPO Network serving Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Kern, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Plumas, Santa Barbara, San Benito, San Joaquin, San Luis Obispo, San Mateo, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura and Yuba counties. Plans issued by Anthem Blue Cross.

Pathway PPO and Pathway HMO Networks serving El Dorado, Fresno, Kings, Madera, Placer, Riverside, Sacramento, San Bernardino, Santa Clara and Yolo counties. Plans issued by Anthem Blue Cross.

Pathway Tiered (EPO) Network serving San Francisco county. Plans issued by Anthem Blue Cross.

Pathway HMO and Pathway Tiered (EPO) Networks serving Los Angeles (North), Los Angeles (South), Orange and San Diego counties. Plans issued by Anthem Blue Cross.

Additional Plan Information
The following plans are issued by Anthem Blue Cross: Anthem Bronze Pathway PPO plans 5000/25%, 5750/20% and 6250/20%; Anthem Bronze Pathway EPO plans 5000/25%, 5750/20% and 6250/20%; Anthem Bronze plans 60 D PPO, 60 D HSA PPO, 60 D EPO and 60 D HSA EPO; Anthem Silver Pathway PPO plans 1750/30% and 2000/25%; Anthem Silver Pathway EPO plans 1750/30% and 2000/25%; Anthem Silver plans 70 D PPO, 70 D EPO and 70 D HMO; Anthem Gold plans 80 D PPO, 80 D EPO and 80 D HMO; Anthem Platinum plans 90 D PPO, 90 D EPO and 90 D HMO; and Anthem Minimum Coverage plans D PPO and D EPO.

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

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, including what's covered and what isn't:

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

In accordance with the Affordable Care Act, benefits, formularies, pharmacy and provider networks, premiums and copayments/coinsurance for these plans may change on January 1 of each year.

The health plans described within this document are not eligible for a premium tax credit/subsidy or cost-sharing assistance. Health care reform, or the Affordable Care Act (ACA), lets people with low or modest incomes use a

premium tax credit to help pay for their health insurance. You can only get financial help if you are eligible and buy your individual health coverage through Covered California.

Medical Loss Ratio
Law requires us to tell you that Anthem Blue Cross' medical loss ratio (MLR) for 2013 was 82.6%. 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.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Snapshot, Coverage Details and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem Authorized Agent to request them.

ZIP code exclusions for HMO plans

Areas served: Pathway X and Pathway networks

County	Exclusions
Los Angeles	**HMO not offered in these ZIP codes:** 90313, 90397, 90398, 90612, 90623, 90630, 90631, 90659, 90704, 90822, 90845, 90888, 91131, 91191, 91310, 91354, 91363, 91383, 91384, 91390, 91399, 91497, 91709, 91797, 91799, 91841, 93243, 93532, 93544
Orange	No excluded ZIP codes in pricing region 18 for HMO
San Diego	**HMO not offered in these ZIP codes:** 91905, 91906, 91916, 91934, 91948, 91962, 91963, 91980, 91987, 91990, 92004, 92066, 92070, 92086, 92090, 92133, 92194

52372CAMENABC 3/15

How to enroll

Sign up today for our dental and vision plans!

For Dental Prime plans:
Fill out a form online or by hand.

- Go to AnthemDentalAdmin.com/ca.
- Or fill out and sign the appropriate form. Then give the form to your agent or mail it to us at:

  Dental Enrollment Department
  P.O. Box 1193
  Minneapolis, MN 55440-1193

Anthem Children's Dental PPO and Anthem Family Dental PPO:

Fill out and sign the form. Give your completed form to your agent or mail it to us at:

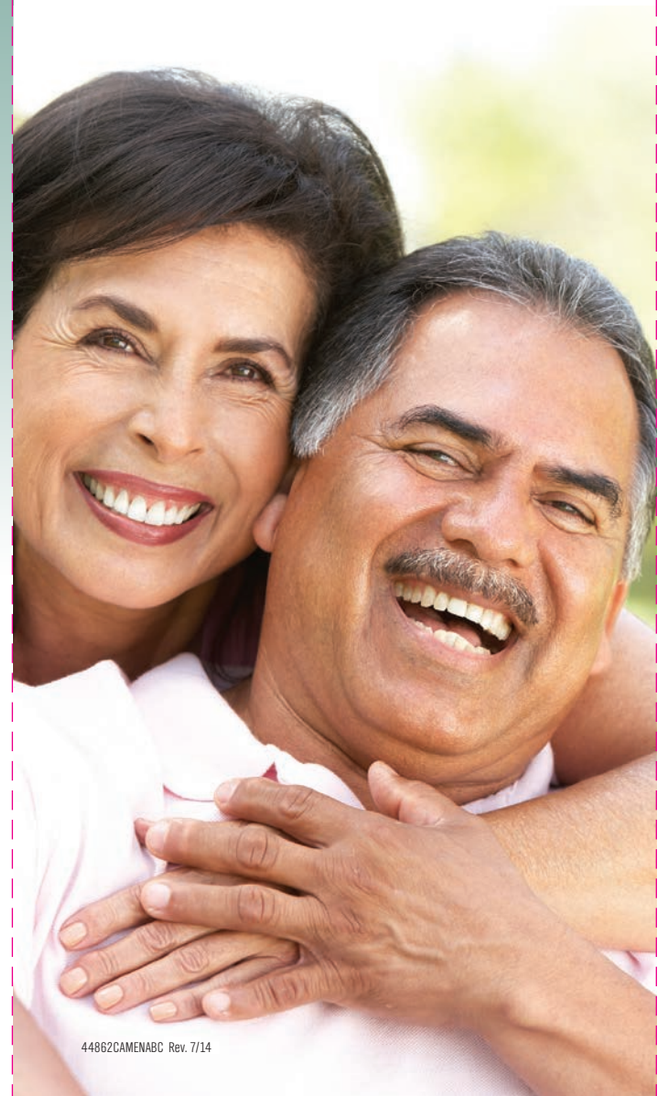
Dental Enrollment Department
P.O. Box 9041
Oxnard, CA 93031-9041

For Anthem Dental Blue PPO plans and Dental SelectHMO plans:

Fill out and sign the form. Give your completed form to your agent or mail it to us at:

Dental Enrollment Department
P.O. Box 9051
Oxnard, CA 93031-9051

Dental and vision coverage for your total health



44862CAMENABC Rev. 7/14

Anthem dental plans

We offer a variety of individual and family dental plan options to fit your needs and budget. These plans include:

- Anthem Children's Dental PPO and Anthem Family Dental PPO
- Dental Prime for Individuals and Families with optional Vision benefits.
- Dental Blue PPO plans
- Anthem Dental SelectHMO plan

Health care reform

Essential health benefits include dental and vision

Pediatric dental is one of the 10 essential health benefits that are included in nearly all individual medical plans as of January, 2014.

Consumers have the following purchase options if they need or want pediatric dental essential health benefits:

- A medical plan that has pediatric dental essential health benefits coverage, **or**
- A standalone pediatric dental essential health benefits policy (Dental Pediatric plan), **or**
- A standalone adult or family dental plan that includes pediatric dental essential health benefits coverage.

On exchange

If you're eligible for a subsidy to help pay for your health coverage and want to use it, you must get your medical plan through the state's health coverage exchange — an online marketplace to purchase health coverage.

To learn more, visit your state's exchange website at coveredca.com.

Off exchange

If you aren't eligible for a subsidy, or if you're shopping for a dental or vision plan, you don't have to buy through the exchange. **You can still get coverage as before, through a broker or agent, or directly from an insurance company.**

Because there are rules for plans on the exchange, you might find that plans off the exchange offer more choices.

Our off-exchange products

Anthem Blue Cross (Anthem) can help you get the dental and vision care you need — which can help you get a better handle on your total health. That's why many of our dental plans include exams, cleanings and X-rays covered 100%, and all of our vision plans include coverage for yearly vision exams.

The table helps you compare your plan choices. So you have many ways to get the smile you want, and keep a healthy mouth.

	Anthem Children's Dental PPO	Anthem Family Dental PPO		Dental Prime			Dental Blue PPO				Dental Select
	Dependents age 18 and younger	*Dependents age 18 and younger*	*Adults age 19+*	*Plan A*	*Plan B*	*Plan C*	*Basic*		*Enhanced*		*HMO*
	In/Out of network						*In network*	*Out of network*	*In network*	*Out of network*	*In network*
Diagnostic & preventive services	No waiting period	No waiting period		No waiting period			No waiting period				No waiting period
Cleaning, exams, x-rays	100%	100%	100%/ 50%	100%	100%	100%	100%	80%	100%	80%	Copayment
Extra cleaning	Not covered	Not covered	Not covered	For those who are pregnant or diabetic			Not covered	Not covered	Not covered	Not covered	Not covered
Basic services	No waiting period	No waiting period		6 month waiting period			6 month waiting period				6 month waiting period (only on fillings where there is no member copay)
Fillings	80%	80%	80% /50%	Not covered	80%	80%	80%	60%	80%	60%	Copayment
Brush biopsy	Not covered	Not covered	Not covered	Not covered	80%	80%	Not covered	Not covered	Not covered	Not covered	Not covered
Complex & major services	No waiting period	No waiting period	6 months waiting period	12 month waiting period			6 month waiting period		12 month waiting period		No waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50%	50%/ 50%	50%/ 50%	Not covered	50%	50%	Not covered		50%	50%	Copayment
Prosthetics (crowns, dentures, bridges)	50%	50%	50%	Not covered	Not covered	50%	Not covered	Not covered	50%	50%	Copayment
Medically necessary orthodontia	50%	50%	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	See Cosmetic orthodontia		See Cosmetic orthodontia
Cosmetic orthodontia	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	50% /$100 deductible/$1,000 lifetime max ($500 per year)		Copayment
Dental network	Dental Prime			Dental Prime			Dental Blue 100				Dental SelectHMO
Deductible (per person)	$65 (waived for D&P services)*	$65 (waived for D&P services)*	$50 (waived for D&P services)	None	$50	$50	$25 (waived for D&P in network only)		$50 per person/$150 per family (waived for D&P in network only)		None
Yearly limit (per person)	None	None	$1,500	$500	$1,000	$1,250	$500		$1,250		None
Yearly out-of-pocket limit	$350**	$350**	None	None	None	None	None	None	None	None	None
International emergency dental program	Included	Included		Included			Included				Included

*Family deductible of $130 for 2 or more children
**$700 for 2 or more children

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

Individual dental and vision premiums for California

Anthem BlueCross

For policies with start dates beginning January 2015

We know that you have choices when it comes to health care coverage. Anthem Blue Cross (Anthem) gives you access to complete dental coverage and one of the largest dental networks in the state. But cost is important to you too.

Because insurance can be a big part of your budget, we make every effort to keep our costs low — so you pay less for coverage. The price you pay for your dental premium depends on several things, including how much dental care costs and where you live.

How much will I pay each month for dental coverage?

Premiums are often set by rating areas. In such a case, to find your monthly cost, look for your rating area based on the ZIP code or county where you live. Then look at the rate charts. Different plans will have different rating areas and rate tables.

44891CAMENABC Rev. 12/14

Dental Blue PPO plans

Where plans are offered

Not all of our Dental Blue plans are offered in all counties. These are the counties where the Dental Blue plan networks are limited:[2]

Area 3: Alpine, Inyo, Mono; Area 4: Calveras; Area 5: Del Norte, Humboldt, Lake, Lassen, Sierra, Siskiyou, Trinity

Rating Area

Alameda	ZIP codes starting with 945, 946 and 953 except 94505, 94514	Area 4
	All other Alameda ZIPs	Area 3
Alpine		Area 3
Amador		Area 3
Butte		Area 5
Calaveras		Area 4
Colusa	95957	Area 3
	All except 95957	Area 5
Contra Costa	All except 94551	Area 3
	94551	Area 4
Del Norte		Area 5
El Dorado		Area 3
Fresno	93313	Area 5
	All except 93313	Area 6
Glenn		Area 5
Humboldt		Area 5
Imperial	92225 and 92274	Area 4
	92004	Area 5
	All except 92225, 92274, 92004	Area 6
Inyo	All except 93527	Area 3
	93527	Area 6
Kern	ZIP codes starting with 933	Area 5
	All other Kern ZIPs	Area 6
Kings		Area 6
Lake		Area 5
Lassen		Area 5
Los Angeles	ZIP codes starting with 901-904 and 913	Area 4
	ZIP codes starting with 905-908, 935, 91709 and 93243	Area 6
	ZIP codes starting with 900, 914 or 916	Area 2
	ZIP codes starting with 910-912, 915, 917 or 918, except 91709	Area 7
Madera		Area 6
Marin		Area 1
Mariposa	95329	Area 4
	All except 95329	Area 6
Mendocino		Area 5
Merced	95380	Area 4
	All except 95380	Area 6
Modoc		Area 5
Mono		Area 3
Monterey	All except 95076 and 93451	Area 1
	95076	Area 4
	93451	Area 6
Napa	94589, 94590	Area 3
	All except 94589, 94590	Area 5
Nevada	95602	Area 3
	All except 95602	Area 5
Orange	ZIP codes starting with 926	Area 5
	All other Orange ZIPs	Area 6
Placer	All except 95692, 96161	Area 3
	95692, 96161	Area 5
Plumas		Area 5
Riverside	ZIP codes starting with 922 except 92248	Area 4
	92028	Area 5
	All other Riverside ZIPs	Area 6
Sacramento	ZIP codes starting with 958	Area 5
	All other Sacramento ZIPs	Area 3
San Benito	93930, 95004	Area 1
	All except 93210, 93930, 95004	Area 4
	93210	Area 6
San Bernardino	All except 91766, 91792	Area 6
	91766 and 91792	Area 7
San Diego		Area 5
San Francisco		Area 3
San Joaquin	94505, 94514, 95632, 95690	Area 3
	All except 94505, 94514, 95632, 95690	Area 4
San Luis Obispo	93426	Area 1
	All except 93426	Area 6
San Mateo	All except 94303	Area 1
	94303	Area3
Santa Barbara		Area 6
Santa Clara	ZIP codes starting with 940, 943	Area 3
	94550, 95023, 95076	Area 4
	All other Santa Clara ZIPs	Area 5
Santa Cruz	All except 95033	Area 4
	95033	Area 5
Shasta		Area 5
Sierra		Area 5
Siskiyou		Area 5
Solano	All except 94503, 95616, 95618, 95694	Area 3
	94503, 95616, 95618, 95694	Area 5
Sonoma		Area 5
Stanislaus	All except 95322	Area 4
	95322	Area 6
Sutter	All except 95645, 95692, 95836, 95948, 95837	Area 3
	95645, 95692, 95836, 95837, 95948	Area 5
Tehama		Area 5
Trinity		Area 5
Tulare		Area 6
Tuolumne	95230, 95329	Area 4
	All except 95230, 95329	Area 6
Ventura	ZIP codes starting with 930 or 932	Area 6
	All other Ventura ZIPs	Area 4
Yolo		Area 5
Yuba		Area 5

Dental Blue Basic

	Area						
	1	2	3	4	5	6	7
Member	$26.00	$28.00	$24.00	$25.00	$24.00	$23.00	$25.00
Member and spouse	$50.00	$54.00	$47.00	$48.00	$47.00	$44.00	$49.00
Member and child	$56.00	$61.00	$53.00	$54.00	$53.00	$49.00	$54.00
Member and children	$94.00	$102.00	$89.00	$90.00	$89.00	$83.00	$91.00
Member and family	$115.00	$124.00	$108.00	$110.00	$108.00	$101.00	$111.00

Dental Blue Enhanced

	Area						
	1	2	3	4	5	6	7
Member	$50.00	$61.00	$50.00	$56.00	$55.00	$52.00	$70.00
Member and spouse	$95.00	$116.00	$95.00	$106.00	$104.00	$97.00	$131.00
Member and child	$90.00	$110.00	$90.00	$100.00	$99.00	$92.00	$125.00
Member and children	$145.00	$177.00	$146.00	$162.00	$160.00	$149.00	$201.00
Member and family	$183.00	$224.00	$184.00	$204.00	$202.00	$188.00	$254.00

Dental Prime plans

Premiums (Annual rates reflect a 5% discount when pre-paying annually)	Plan A		Plan B		Plan C	
	Monthly	*Annual*	*Monthly*	*Annual*	*Monthly*	*Annual*
ZIP codes starting with 922-925, 932-938, 952-953, 955, 959-961						
Individual	$24.05	$274.15	$37.05	$422.35	$46.80	$533.50
Individual + 1	$46.75	$532.95	$72.05	$821.35	$91.00	$1,037.40
Family	$74.85	$853.30	$115.25	$1,313.85	$145.60	$1,659.85
ZIP codes starting with 900-921, 926-931, 939, 942, 954, 956-958						
Individual	$28.95	$330.05	$44.60	$508.45	$56.35	$642.40
Individual + 1	$56.30	$641.80	$86.70	$988.40	$109.55	$1,248.85
Family	$90.10	$1,027.15	$138.75	$1,581.75	$175.25	$1,997.85
ZIP codes starting with 940-941, 943-951						
Individual	$32.30	$368.20	$49.75	$567.15	$62.85	$716.50
Individual + 1	$62.80	$715.90	$96.75	$1,102.95	$122.20	$1,393.10
Family	$100.50	$1,145.70	$154.80	$1,764.70	$195.55	$2,229.25

Blue View Vision plans

This vision option is available only when combined with Dental Prime for Individuals and Families

Premiums (Annual rates reflect a 5% discount when pre-paying annually)	Monthly	Annual
Individual	$7.98	$90.97
Individual + 1	$13.97	$159.20
Family	$22.35	$254.79

Dental SelectHMO counties

The Dental Plan's current service area comprises the following counties and parts of counties: Alameda County, Contra Costa, El Dorado except for Placerville and Lake Tahoe, Fresno, Kern except for Delano, Mojave, Taft, and Tehachapi, Kings except for Hanford, Los Angeles Marin Monterey except for Salinas, Orange Placer except for Lake Tahoe, Riverside except for Banning/ Beaumont, Blythe, Twenty-Nine Palms and vicinity and Yucca Valley, Sacramento San Bernardino San Diego San Francisco San Joaquin San Luis Obispo San Mateo Santa Barbara Santa Clara Santa Cruz except for Santa Cruz, Solano Sonoma Tulare except for Visalia, Ventura except for Santa Paula/Fillmore.

Monthly rates for Dental SelectHMO plan enrollees for all ages[1]	
Single	$17.40
Two people (member and spouse or member and child)	$35.50
Family (three or more) (member, spouse and child or member and children)	$53.30

1 Subject to change.

Rates apply to members under age 65 and are subject to change (except where noted).

As of January 1, 2014, the Affordable Care Act (ACA) or health care reform law, requires health insurers to pay an annual fee to fund premium subsidies and Medicaid expansion. This fee applies to fully insured dental and vision plans. The monthly premiums listed above include the ACA insurer fee.