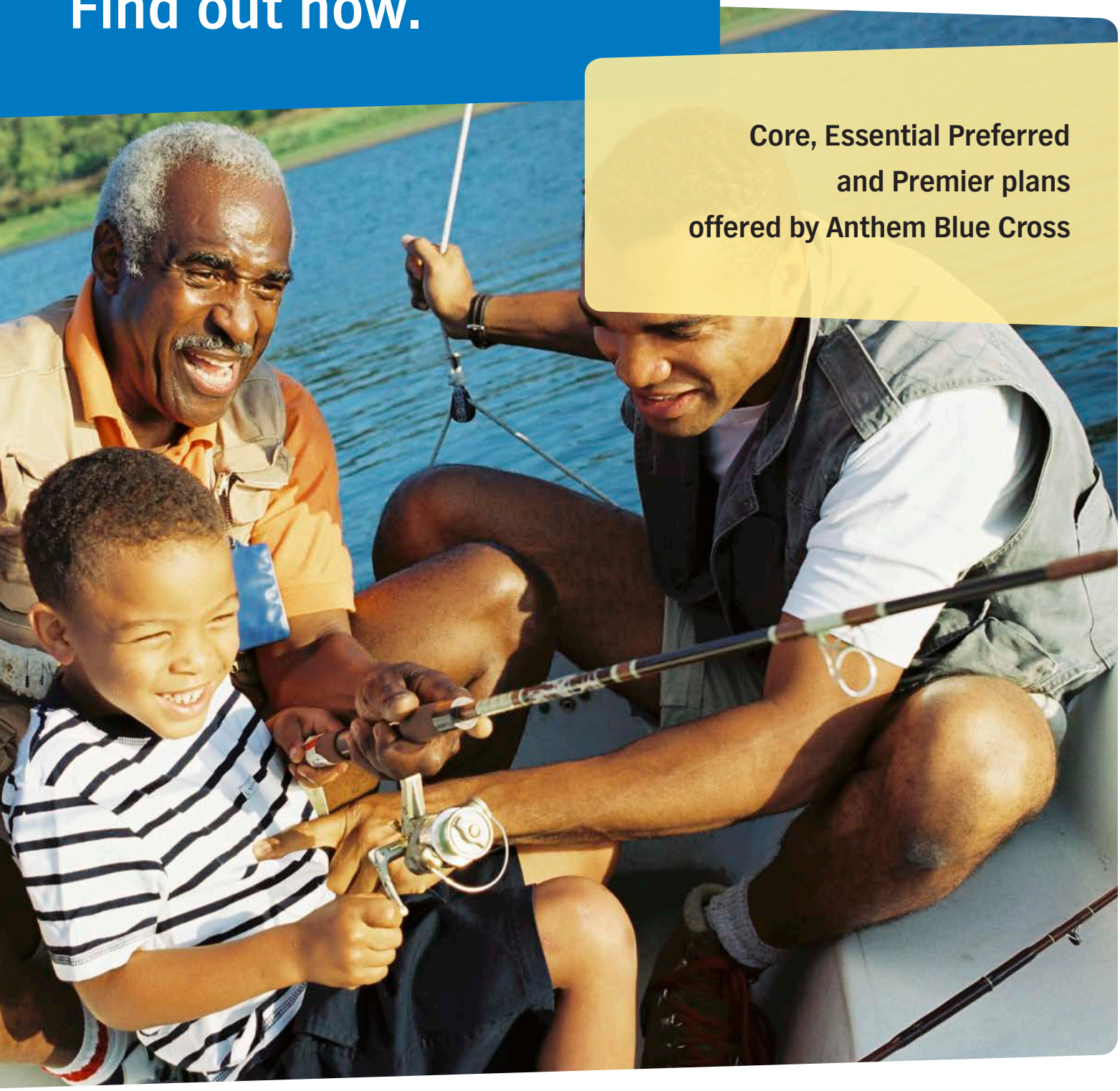
Anthem BlueCross

Individual and family health benefit plans for California

We make it easy. Find out how.



Core, Essential Preferred and Premier plans offered by Anthem Blue Cross

Health care may never be simple, but choosing the right plan can be.

When it comes to Individual health care coverage, it's not one-size-fits-all. With Anthem Blue Cross (Anthem), you get a wide 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.

To learn more about your options, review this information with your Anthem Authorized Agent.

Total health solution

We offer you a total health solution, so you can live healthier, feel better and save money doing it. With Anthem, you get:

- Easy-to-use tools to find a doctor, hospital, provider or pharmacy
- Preventive care, like checkups and flu shots at no additional cost
- 24/7 NurseLine
- Online support to manage your plan
- Reliable customer service

Network value

Access to the best doctors in your area is important. And we've created our network of doctors and hospitals with this in mind. Our goal is to work with doctors and hospitals who will offer the best care possible — at a lower cost. Our networks include:

- Doctors and hospitals
- Lab, durable medical equipment and behavioral health providers
- Urgent and emergency providers

A friendly face in a changing world

Health care is changing but one thing is clear: we're here to provide health care benefits to people like you — now and in the future. Starting in 2014, all Americans must have health coverage or pay a tax penalty. In fact, you can't be turned down! You can purchase coverage direct from Anthem or through Covered California. In some cases, the government may even help pay for your coverage. Get the health care coverage you need from Anthem.

Get help today!

Call your Anthem Authorized Agent or visit us online where you can view and compare plan options.

How Health Care Coverage 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. 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 non-HSA 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. For HSA qualified plans, either one or more family members must meet the family deductible before any covered services that are subject to the deductible will be paid by the plan. The family out-of-pocket limit can be met by either one or more members. Once the limit is met, no additional coinsurance will be required for the family for the remainder of the calendar year.

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 portion of the plan's $2,000 deductible.)

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.

- *Remaining cost of surgery:* $34,000
- *Coinsurance: 30%* (30% of $34,000 = $10,200)
- *In order to determine what John would actually pay for coinsurance, we need to look at his 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 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 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.

- *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

Covering you A to Z

All of our plan options have one major goal in mind: Making sure you stay healthy and that you get access to the quality care you need when you need it. That's why, no matter which plan you choose, you're covered for preventive care to emergencies, and more!

What's covered?

- [1]Preventive and wellness services and help managing a chronic (ongoing) disease
- Outpatient (ambulatory) patient care
- Emergency services
- Inpatient care (care received when you stay overnight in a hospital)
- Laboratory services
- Prescription drugs
- Rehabilitative and habilitative services (habilitative services help a person learn, keep or improve skills they may not be developing normally after an illness or injury)
- Mental health and substance abuse services
- Maternity (pregnancy) and newborn care
- Pediatric services (health care for children)

Don't forget dental and vision coverage. Check out our Anthem dental and vision plans. Just call your Anthem Authorized Agent or go online to anthem.com/ca for details.

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 your prescription drug plan and the choices you have when it comes to selecting and paying for these medications.

To find out if your medication is covered, take a look at our drug list at anthem.com/ca > Customer Support > Forms Library > Anthem Select Drug List. Covered medications are assigned to certain tiers (or levels) based on cost, availability and similar alternatives. By selecting a Tier 1 medication, you may have a lower cost share. You can usually save money by selecting a generic version of a medication. Or even save time by having medicine sent right to your home. Always talk to your doctor first about which medication is right for you.

Please visit our Find a Doctor tool on anthem.com/ca to see if your pharmacy is in-network.

Access coverage for emergency and urgent care services — 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. However, 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.

Take care of yourself with no-cost preventive care

Anthem's preventive care coverage options give you access to any of our 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-network.

[1]Preventive and wellness services consist of services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

Your plan options

We offer plans to fit your health care coverage needs — and your budget. To make it easy to compare and choose a plan, they are split into four different levels — Core, Essential, Preferred and Premier. Your costs and coverage increase with each level.

Core	With the Core plans, 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.
Essential	The Essential plans still have low monthly premiums but you pay less when you get care. However, the monthly premium is higher than the Core plan.
Preferred	With the Preferred plan, you have richer benefits and pay less when you get care. However, the monthly premium is higher than the Core and Essential plans.
Premier	You enjoy the highest level of benefits and often pay less when you get care. However, you pay the highest monthly premiums with the Premier plan.

Make your health care dollars work harder with a Health Savings Account

A Health Savings Account (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. HSA-compatible health care plans work with or without this savings account, the choice is yours.

Plan choices that are HSA-compatible include HSA in the plan name. Check with your tax advisor to see if an HSA plan is right for you and check out the insert from our preferred banking partner.

What doctors can I see?

We offer two different types of health plans: **DirectAccess** and **Guided Access**.

With our **DirectAccess** 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 select a PCP.

With **Guided Access** plans, you must choose an in-network PCP who helps to coordinate your care. When you see other doctors, you may need to get a referral from your primary care physician.

What is an in-network provider?

When you need care, you will get the best value by visiting an **in-network** doctor, hospital or other health care provider. **In-network** (or participating) refers to doctors and 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 are 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. On some plans, you have the choice to visit an **out-of-network** doctor or hospital, 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.

What is a tiered network?

Most of our 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. You can find out what tier a hospital is in through our Find a Doctor tool at anthem.com/ca.

Easy-to-use online member tools

Anthem's website is an easy-to-use resource that allows you to manage your health care in a simple and convenient way. With our website, you can:

- Find a summary 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 clear estimates using our out-of-pocket cost calculator.

Get help from nurses 24/7

Anthem's 24/7 NurseLine gives you access to trained registered nurses any time of the day or night for answers to your general health questions, to help you understand your symptoms and to help you determine the right care at the right time.

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.

Zagat® Health Survey

It's similar to the restaurant survey. See what other patients have said about the doctors and hospitals you're thinking about using. Add your own doctor reviews, too!

Access 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.

Save time and money with an urgent care center or retail health clinic

You can 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 can help find care alternatives to the ER like urgent care centers, walk-in doctors' offices and retail health clinics.

Tips for picking a health plan

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.

- **Make sure the plan will meet your health care coverage needs.** Think about how often you see doctors and specialists and what prescription medications you take.
- **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 an in-network doctor 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 best meets your health care coverage needs and budget.
- **Consider making contributions to a Health Savings Account (HSA).** Making post-tax contributions to an HSA can help make your money go further. Talk to your financial advisor about potential tax advantages.

Am I required to have coverage for pediatric dental benefits?

Yes. This coverage is required to be included with every medical plan regardless of the applicant's age and whether or not they have children. If the medical plan you purchase does not include pediatric dental, you will be required to purchase a separate pediatric dental plan.

Do I qualify to get help paying for my 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 can I purchase a plan?

Plans can be purchased once a year through an open enrollment period. Open enrollment is from October 1 through March 31. If you want an effective date of January 1, you must make a selection by December 15, 2013. Check with your Anthem Authorized Agent for effective date options and guidelines around enrollment during other times of the year.

How do I enroll in an Anthem plan?

- If you are ready to enroll or would like more information about the health care plans offered by Anthem, call your Anthem Authorized Agent today!
- If you do not have an Anthem Authorized Agent, visit our website at anthem.com/ca and apply online.

Anthem BlueCross

Get help today!

Call your Anthem Authorized Agent or visit us online where you can view and compare plan options.

We want you to be satisfied

After you enroll in a plan offered by Anthem you will receive a Contract or Certificate of Coverage that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 10 days to examine your plan's features. During that time, if you are not fully satisfied, you may cancel your policy and your premiums 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 plan/policy may be continued in force or discontinued. For more complete details, including what's covered and what isn't:

- See the coverage details document included with this brochure.
- Call your Anthem Authorized Agent.
- Go to anthem.com/ca.

For more information on how to access a Summary of Benefits and Coverage (SBC), please visit www.healthcare.gov and enter SBC in the search field.

The health plans described within this document are not eligible for a premium tax credit subsidy.

The following plans are issued by Anthem Blue Cross: Anthem Core DirectAccess – caae, caan, caao, cacf, cacg, cacj, cacl and cacs, Anthem Core DirectAccess with Child Dental - cdae and cdao, Anthem Core DirectAccess with HSA - cach and caci, Anthem Essential DirectAccess – cbmm, cbmq, cbng, cbnk, cbno and cbns, Anthem Essential Guided Access – cbmu, Anthem Preferred DirectAccess – ccas and ccat, Anthem Preferred Guided Access – ccau, Anthem Premier DirectAccess – ceab and ceac and Anthem Premier Guided Access – cead.

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.

ACS | BNY Mellon is an independent corporate entity that provides banking administration on behalf of Anthem Blue Cross.

Coverage Details for California

Things you need to know before you buy....

Anthem Core DirectAccess, Anthem Core DirectAccess with Child Dental, Anthem Core DirectAccess with HSA, Anthem Essential DirectAccess, Anthem Essential Guided Access, Anthem Preferred DirectAccess, Anthem Preferred Guided Access, Anthem Premier DirectAccess, Anthem Premier Guided Access, Anthem Catastrophic DirectAccess issued by Anthem Blue Cross

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.

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:
   a. Individual who no longer resides, lives or works in the Plan's service area,
   b. A situation in which the Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
   c. Termination of employer contributions, and
   d. 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.

Not an Annual Agreement

THIS IS NOT AN ANNUAL AGREEMENT. The Plan period is monthly and defines the period of your coverage but does not affect and is not affected by any provisions defining your deductible or other cost-sharing obligations which are calculated on a yearly basis. Your Agreement expires at the end of each monthly plan period but will automatically renew upon timely payment by the monthly premium due date of the premium for the next monthly plan period, unless we have exercised our right to terminate, cancel or non-renew as described in this Agreement. Premiums, benefits, terms, deductibles, Out-of-pocket limits and conditions may be modified effective at any renewal date following sixty (60) days written notice to you, and such changes may be implemented at any time during the next plan period following renewal. As a member, please read your Agreement, and in particular, all the sections under the parts "Right to Modify or Change the Agreement: and "Your Eligibility" carefully and in its entirety to make sure you fully understand the duration of your coverage and the conditions under which we can change, terminate, cancel or decline to renew your Agreement.

 All product offerings are subject to regulatory review and approval.

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

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 1-855-383-7247 to ensure that you can obtain the health care services that you need.

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

To see a physician, call their office:

- Tell them you are an Anthem member,
- Have your Member Identification Card handy. The physician's office may ask you 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 Card with you.

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 your Plan. You can also find out where they are located and details about their license or training.

- See our directory of in-network providers at anthem.com/ca, which lists the physicians, providers and facilities that participate in our network.
- Call customer service at **1-855-383-7247**, to ask for a list of physicians, providers and facilities that participate in our network, based on specialty and geographic area.
- Check with your physician or provider.

If you need help finding a doctor in our network, call the customer service number at **1-855-383-7247**, the 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-network for one Plan may not be in-network for another. Be sure to call customer service to find out which network your Plan will use.

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 your Agreement
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Charges greater than the negotiated fee rate (charges exceeding the amount Anthem recognizes 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 your 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
- Pharmacy, except as described in your 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 your 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
- Home health care - 100 visits
- Skilled nursing facility - 100 days

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.

Pathway PPO and Pathway HMO Networks serving El Dorado, Fresno, Kings, Madera, Placer, Riverside, Sacramento, San Bernardino, Santa Clara and Yolo Counties.

Pathway Tiered Network serving San Francisco County.

Pathway HMO and Pathway Tiered Networks serving Los Angeles (North), Los Angeles (South), Orange and San Diego Counties.

Additional Plan Information

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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.

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