



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.anthem.com/ca](http://www.anthem.com/ca) or by calling 1-855-333-5730.

Important Questions	Answers	Why this Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p>For PPO Providers &amp; Other Health Care Providers  <b>\$0</b> Individual/ <b>\$0</b> Family                      For Non-PPO Providers  <b>\$250</b> Member/<b>\$750</b> Family                      Deductible's are a combined accumulation. Does not apply to Preventive Care, Office Visit Copayments, Hospice and Prescription Drugs In-Network Provider and Non- Network. Provider deductibles are combined. Satisfying one helps satisfy the other.</p>	<p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the <u>deductible</u>.</p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>Yes. <b>\$100</b> Member/ <b>\$300</b> Family Deductible for Brand Prescription Drugs.  <b>\$500</b>/Admission for Non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained (waived for emergency admission).  <b>\$25</b>/Visit for Emergency Room services (waived if admitted directly from ER).</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.</p>

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<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes. For PPO Providers &amp; Other Health Care Providers  <b>\$1,000</b> Member/<b>\$0</b> Family                  For Non-PPO Providers  <b>\$3,000</b> Member/<b>\$0</b> Family</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, Prescription drug copays, Balance-bill charges and Health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No.</p>	<p>The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>
<p>Does this plan use a <u>network of providers</u>?</p>	<p>Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call 1-855-333-5730, for a list of PPO Providers.</p>	<p>If you use an in-network doctor or other health care <u>provider</u>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u>, or participating for <u>providers</u> in their <u>network</u>. See the chart starting on page 3 for how this plan pays different kinds of <u>providers</u>.</p>
<p>Do I need a referral to see a <u>specialist</u>?</p>	<p>No. You don't have a referral to see a specialist.</p>	<p>You can see the <u>specialist</u> you choose without permission from this plan.</p>
<p>Are there services this plan doesn't cover?</p>	<p>Yes.</p>	<p>Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about <u>excluded</u> services.</p>



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

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Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	<b>\$15</b> Copay/Visit	<b>30%</b> Coinsurance	_____none_____
	Specialist visit	<b>\$15</b> Copay/Visit	<b>30%</b> Coinsurance	_____none_____
	Other practitioner office visit	<u>Chiropractor</u> <b>10%</b> Coinsurance <u>Acupuncture</u> <b>10%</b> Coinsurance	<u>Chiropractor</u> <b>30%</b> Coinsurance <u>Acupuncture</u> <b>30%</b> Coinsurance	<u>Chiropractor</u> Coverage is limited to 24 visits per calendar year. Additional visits maybe authorized. Services from In-Network and Non-Network providers count towards your calendar limit. Chiropractic visits count towards your physical and occupational therapy limit. <u>Acupuncture</u> Coverage is limited to 12 visits for In-Network and Non-Network Providers/per calendar year.
	Preventive care/screening/immunization	No Cost Share	<b>30%</b> Coinsurance	_____none_____
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	<u>Lab-Office</u> <b>10%</b> Coinsurance <u>X-Ray-Office</u> <b>10%</b> Coinsurance	<u>Lab-Office</u> <b>30%</b> Coinsurance <u>X-Ray-Office</u> <b>30%</b> Coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	<b>10%</b> Coinsurance	<b>30%</b> Coinsurance	Coverage is limited to <b>\$800</b> per procedure for Non-PPO Providers. Costs may vary by site of service.

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Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&amp;provtype=Rx">www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&amp;provtype=Rx</a></p>	<p>Generic drugs (<i>includes diabetic supplies</i>)</p>	<p><b>\$10</b> Copay/ prescription (retail and home delivery)</p>	<p><b>\$10</b> Copay/ prescription plus <b>50%</b> of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</p>	<p>For Non-Participating Pharmacies: Member pays the retail pharmacy copay plus <b>50%</b>. Covers up to a 30 day supply for Retail pharmacy or a 90 day supply for Home Delivery. For Non-Participating Pharmacies, compound drugs &amp; certain specialty pharmacy drugs may require preauthorization or are not covered. 30-day supply; 60-day supply for Federally Classified Schedule II Attention Deficit Disorder drugs that require a triplicate prescription require double copay available only at a Retail Pharmacy.</p>
	<p>Brand name formulary drugs</p>	<p><b>\$25</b> Copay/ prescription (retail) <b>\$50</b> Copay/ prescription (home delivery)</p>	<p><b>\$25</b> Copay/ prescription plus <b>50%</b> of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</p>	
	<p>Brand name non-formulary drugs (<i>includes compound drugs; retail only</i>)</p>	<p><b>\$40</b> Copay/ prescription (retail) <b>\$80</b> Copay/ prescription (home delivery)</p>	<p><b>\$40</b> Copay/ prescription plus <b>50%</b> of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</p>	

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	Specialty Drugs ( <i>includes self-administered injectable drugs, except insulin</i> )	<b>\$10</b> Copay/ prescription for Generic drugs <b>\$25</b> Copay/ prescription for Brand name formulary drugs <b>\$40</b> Copay/ prescription for Brand name non-formulary drugs <b>20%</b> Coinsurance (retail only) with <b>\$150</b> max and <b>20%</b> Coinsurance (home delivery) with <b>\$300</b> max	<b>50%</b> Coinsurance	For Non-Network: Member pays the retail pharmacy copay plus <b>50%</b> . For Non-Participating Pharmacies, compound drugs & certain specialty pharmacy drugs require preauthorization or are not covered 30-day supply for Specialty Pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	<b>10%</b> Coinsurance	<b>30%</b> Coinsurance	Benefit is limited to <b>\$350</b> per admit for Non-PPO providers.
	Physician/surgeon fees	<b>10%</b> Coinsurance	<b>30%</b> Coinsurance	—————none—————
<b>If you need immediate medical attention</b>	Emergency room services	<b>10%</b> Coinsurance	<b>10%</b> Coinsurance	Additional deductible of <b>\$25</b> applies, waived if admitted in patient. This is for the hospital/facility charge only. The ER physician charge may be separate.
	Emergency medical transportation	<b>10%</b> Coinsurance	<b>10%</b> Coinsurance	—————none—————
	Urgent care	<b>\$15</b> Copay/Visit	<b>30%</b> Coinsurance	Costs may vary by site of service. You should refer to your formal contract of coverage for details.

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Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	30% Coinsurance	Failure to obtain preauthorization may result in non-coverage or an additional <b>\$500</b> deductible for non-participating providers, waived for emergency admissions.
	Physician/surgeon fee	10% Coinsurance	30% Coinsurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	<u>Mental/Behavioral Health Office Visit</u> \$15 Copay/Visit <u>Mental/Behavioral Health Facility Visit-Facility Charges</u> 10% Coinsurance	<u>Mental/Behavioral Health Office Visit</u> 30% Coinsurance <u>Mental/Behavioral Health Facility Visit-Facility Charges</u> 30% Coinsurance	—————none—————
	Mental/Behavioral health inpatient services	10% Coinsurance	30% Coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.
	Substance use disorder outpatient services	<u>Substance Abuse Office Visit</u> \$15 Copay/Visit <u>Substance Abuse Facility Visit-Facility Charges</u> 10% Coinsurance	<u>Substance Abuse Office Visit</u> 30% Coinsurance <u>Substance Abuse Facility Visit-Facility Charges</u> 30% Coinsurance	—————none—————
	Substance use disorder inpatient services	10% Coinsurance	30% Coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.
If you are pregnant	Prenatal and postnatal care	10% Coinsurance	30% Coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.

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	Delivery and all inpatient services	10% Coinsurance	30% Coinsurance	Failure to obtain preauthorization may result in non-coverage or an additional <b>\$500</b> deductible for non-participating providers, waived for emergency admissions.
<b>If you need help recovering or have other special health needs</b>	Home health care	10% Coinsurance	30% Coinsurance	Coverage is limited to a total of 100 visits, In-Network Provider and Non-Network Provider combined per calendar year (one visit by a home health aide equals four hours or less). Services from In-Network Provider and Non-Network Provider count towards your limit.
	Rehabilitation services	10% Coinsurance	30% Coinsurance	Coverage is limited to 24 visits combined for Occupational, Physical and Speech therapies including Chiropractor services. Services from In-Network and Non-Network providers. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Habilitation services	10% Coinsurance	30% Coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	10% Coinsurance	30% Coinsurance	Coverage is limited to a combined total of 100 days per calendar year for services received from In-Network & Non-Network Providers.
	Durable medical equipment	10% Coinsurance	30% Coinsurance	_____none_____
	Hospice service	No Cost Share	30% Coinsurance	_____none_____
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	_____none_____
	Glasses	Not Covered	Not Covered	_____none_____
	Dental check-up	Not Covered	Not Covered	_____none_____

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**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless you have been diagnosed with diabetes. Consult your formal contract of coverage)
- Weight Loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric Surgery (For morbid obesity. Consult your formal contract of coverage)
- Chiropractic Care
- Hearing aids (1 per ear/every 3 years)
- Most coverage provided outside the United States. See [www.bcbs.com/bluecardworldwide](http://www.bcbs.com/bluecardworldwide)

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-333-5730. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

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## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross  
Grievance and Appeals  
P.O. Box 4310  
Woodland Hills, CA 91367

Department of Labor's Employee Benefits Security Administration  
1-866-444-EBSA (3272)  
[www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

California Department of Insurance  
300 South Spring St.  
Los Angeles, CA 90013  
1-800-927-4357  
[www.insurance.ca.gov](http://www.insurance.ca.gov)

Additionally, a consumer assistance program can help you file your appeal. Contact:

California Department of Managed Care  
California Help Center  
980 9<sup>th</sup> St., Suite 500  
Sacramento, CA 95814-2725  
1-888-466-2219  
[www.dmhc.ca.gov](http://www.dmhc.ca.gov)  
[www.healthhelp.ca.gov](http://www.healthhelp.ca.gov)  
[helpline@dmhc.ca.gov](mailto:helpline@dmhc.ca.gov)

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### **Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.”

**This plan or policy does provide minimum essential coverage.**

### **Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

### **Language Access Services:**

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íinízinigo t'áá diné k'éjígó, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daq iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'niilígú bi'kéhgo bich'í hodiilní.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$6,840
- **Patient pays** \$700

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$30
Coinsurance	\$520
Limits or exclusions	\$150
<b>Total</b>	<b>\$700</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,630
- **Patient pays** \$770

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$550
Coinsurance	\$140
Limits or exclusions	\$80
<b>Total</b>	<b>\$770</b>

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [www.anthem.com/ca](http://www.anthem.com/ca) or call 1-855-333-5730.

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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