



Authorized Independent Agent for Anthem Blue Cross of California and Anthem BC Life Health Insurance Company

California Association of REALTORS®

2012 Anthem Blue Cross of California

Medical Plans Benefit Summary (1)



Benefits shown are for Preferred Providers ONLY. Benefits shown are always based on the Blue Cross allowed amount. Benefits for Non Preferred Providers are significantly reduced.

Plans marked with: * Offered by Anthem Blue Cross ** Offered by Anthem Blue Cross Life and Health Insurance Company	Premier PPO \$20 Copay *	PPO \$30 Copay *	PPO \$35 Copay GenRx **	Lumenos HSA 3500 (80/50)**	Saver \$20 HMO *
Calendar Year Deductible	\$250/member Two member maximum	\$500/member Two member maximum	\$500/member Two member maximum	\$3500/person \$7000/family aggregate; medical/pharmacy combined (5,6)	No Deductible
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Annual Out of Pocket Maximum (2) (Includes annual deductible)	\$3500/member Two member maximum	\$4500/member Two member maximum	\$4500/member Two member maximum	\$5000/member; \$10000/family aggregate; medical/pharmacy combined (5,6)	\$2500/member, \$5000/family aggregate(6)
ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED					
Office Visits	\$20 copay (3)	\$30 Copay (3)	\$35 Copay (3)	20% after deductible	Primary \$20 copay - Specialist \$30 copay
Professional Services (Including maternity, diagnostic lab & X- rays)	20% of maximum allowed amount	30% of maximum allowed amount	35% of maximum allowed amount	20% of maximum allowed amount	\$100 copay for complex radiology services obtained in a hospital or non-hospital based facility. Office visit copay may apply for maternity services.
Emergency Care	\$150 Copay + 20% of maximum allowed amount	\$150 Copay + 30% of maximum allowed amount	\$150 Copay + 35% of maximum allowed amount	20% of maximum allowed amount	No charge after \$150 copay
Hospital Inpatient Facility Services (Preservice Review required)	20% of maximum allowed amount	30% of maximum allowed amount	35% of maximum allowed amount	20% of maximum allowed amount	\$400 per day, up to 3 days maximum copay
Hospital Inpatient Professional Services (Lab, physician, anesthesia)	20% of maximum allowed amount	30% of maximum allowed amount	35% of maximum allowed amount	20% of maximum allowed amount	No charge
Outpatient Facility Services (Pre-service Review required for certain surgical services and diagnostic procedures)	20% of maximum allowed amount	30% of maximum allowed amount	35% of maximum allowed amount	20% of maximum allowed amount	Surgery: \$300 copay per admission Physical therapy, occupational therapy, speech therapy; radiation, chemo and infusion therapy; other outpatient facility services (example blood services and clinic visits): \$30 /visit
Prescription Drugs		\$150 annual per member brand-name drug deductible	None Brand: Not covered	After combined annual medical/pharmacy deductible is met	\$150 annual per member brand-name drug deductible
Brand Name Drug Deductible	None				
Retail Participating Pharmacy (30 day supply) Copay is determined by tier as listed on the tiered drug formulary list. For more information consult your physician or visit www.anthem.com/ca , click on Customer Care	Tier 1: \$10 copay Tier 2: \$30 copay (4) Tier 3: \$50 copay (4) Tier 4: 30% of prescription drug maximum allowed amount up to a maximum \$150 copay per prescription	Tier 1: \$10 copay Tier 2: \$30 copay (4) Tier 3: \$50 copay (4) Tier 4: 30% of prescription drug maximum allowed amount up to a maximum \$150 copay per prescription (4)	Generic: \$10 copay Tiers 2,3,4: Not covered	Tier 1: \$10 copay Tier 2: \$30 copay (4) Tier 3: \$50 copay (4) Tier 4: 30% of prescription drug maximum allowed amount	Tier 1: \$10 copay Tier 2: \$30 copay (4) Tier 3: \$50 copay (4) Tier 4: 30% of prescription drug maximum allowed amount up to a maximum \$150 copay per prescription (4)
Specialty Pharmacy Drugs (30 day supply) May only be obtained through the specialty pharmacy program. - Tier 4: Prescription drug copayments will accrue to a maximum of \$3,500 per member per year. Once the member has satisfied the \$3,500 maximum, no additional copayments will be required for the remainder of the year for Tier 4 prescription drugs.	Tier 4: 30% of prescription drug maximum allowed amount up to a maximum \$150 copay per prescription	Tier 4: 30% of prescription drug maximum allowed amount up to a maximum \$150 copay per prescription (4)	Not covered	Tier 4: 30% of prescription drug maximum allowed amount	Tier 4: 30% of prescription drug maximum allowed amount up to a maximum \$150 copay per prescription (4)
Preventive Care Services including physical exams, preventive screenings, flu vaccine, immunizations, health education, intervention services, and HIV testing. (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision)	No copay (deductible waived)	No copay (deductible waived)	No copay (deductible waived)	No copay (deductible waived)	No copay
Ambulance	20% of maximum allowed amount	30% of maximum allowed amount	35% of maximum allowed amount	20% of maximum allowed amount	\$150 copay/trip

(1) This document is a summary of benefits only. Refer to contract for a detailed explanation of plan benefits, features, exclusions and limitations. Benefits valid for plan year 6/1/12 to 5/31/13 and subject to change without notice. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: www.RealCareCAR.com

(2) Annual out-of-pocket maximum: Expenses that contribute to the maximum payment limit vary from plan to plan and have restrictions and limitations. Refer to each plan's Combined Evidence of Coverage and Disclosure Former Certificate for full details.

(3) Not subject to plan deductible.

(4) If a member selects a brand name drug when a generic drug substitution exists, even if the member's physician has specified "dispense as written" (DAW) or do not substitute, the member will be responsible for tier 1 copay, plus the difference between the cost of the generic drug and the cost of the brand name drug.

(5) Lumenos HSA 3500 (80/50) In and out of network plan annual deductible and annual out of pocket maximums are not combined; medical/pharmacy are combined.

(6) Per family amount is aggregate, i.e., if one or more family member's eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members.

Note: A high-deductible health plan is not an HSA. An HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Consultation with a tax advisor is recommended.