Anthem Blue Cross

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

California Association of REALTORS®

January - December 2019 Anthem Blue Cross of California

Bronze PPO Medical Plans Benefit Summary [1]

RealCare Insurance Marketing Inc

Benefits shown are what YOU WILL PAY for Preferred Providers ONLY.
Benefits shown are always based on the Blue Cross covered expense.
Benefits for Non Preferred Providers are significantly reduced.

Plans offered by Anthem Blue Cross of California ***Small Group Prudent Buyer PPO Network***	**Bronze PPO 6600/0% (3KDB)** **HSA COMPATIBLE PLAN**	**Bronze PPO 5000/45% (3KD3)** **HSA COMPATIBLE PLAN**	**Bronze PPO 70/6300/35% (3KER)**	**Bronze PPO 40/5600/40% (306D)**	**Bronze PPO 65/4600/40% (3KJ9)**
Calendar Year Deductible	Individual: $6,600 Family: $13,200	Individual: $5,000 Family: $10,000	Individual: $6,300 Family: $12,600	Individual: $5,600 Family: $11,200	Individual: $4,600 Family: $9,200
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $6,600 Family: $13,200	Individual: $6,750 Family: $13,500	Individual: $7,900 Family: $15,800	Individual: $7,900 Family: $15,800	Individual: $7,900 Family: $15,800
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED				
Office Visits (Primary Care/Specialist)	0% of covered expense after deductible	45% of covered expense after deductible	$70/$85 for first 3 visits, then ded. and $70/$85	$40/$80 for first 3 visits, then ded. and $40/$80	$65/$85 for first 3 visits, then ded. and $65/$85
Preventive Care Services including physical exams and covered preventive screenings	No copay (deductible waived)	No copay (deductible waived)	No copay (deductible waived)	No copay (deductible waived)	No copay (deductible waved)
Diagnostic Services Lab, X-Ray Imaging (MRI/CT/PET)	0% of cov. expense after ded. 0% of cov. expense after ded.	45% of cov. expnse after ded. 45% of cov. expnse after ded.	35% of cov. expnse after ded. 35% of cov. expnse after ded.	40% of cov. expnse after ded. 40% of cov. expnse after ded.	40% of cov. expnse after ded. 40% of cov. expnse after ded.
Emergency Care Facility Doctor Services	0% of cov. expense after ded. 0% of cov. expense after ded.	45% of cov. expns after ded. 45% of cov. expns after ded.	$200 + 35% of coinsurance after ded. 35% of cov. expnse after ded.	$200 + 40% of coinsurance after ded. 40% of cov. expnse after ded.	50% coinsurance after ded.
Ambulance	0% of covered expense after deductible	45% of covered expense after deductible	35% of covered expense after deductible	40% of covered expense after deductible	40% of cov. expnse after ded.
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	0% of covd. exp. after ded. 0% of covd. exp. after ded.	45% of covd. exp. after ded. 45% of covd. exp. after ded.	35% of covd. exp. after ded. 35% of covd. exp. after ded.	40% of covd. exp. after ded. 40% of covd. exp. after ded.	40% of covd. exp. after ded. 40% of covd. exp. after ded.
Outpatient Surgery Facility Fee Doctor Services	0% of covd. exp. after ded. 0% of covd. exp. after ded.	45% of covd. exp. after ded. 45% of covd. exp. after ded.	35% of covd. exp. after ded. 35% of covd. exp. after ded.	40% of covd. exp. after ded. 40% of covd. exp. after ded.	40% of covd. exp. after ded. 40% of covd. exp. after ded.
Prescription Drug Benefits			**Anthem Select Drug List**		
Prescription Drug Deductible	Combined with Medical deductible	Combined with Medical deductible	Tier 1: No Deductible Tiers 2-4: Medical Deductible Applies	Tier 1: No Deductible Tiers 2-4: Medical Deductible Applies	Tier 1: No Deductible Tiers 2-4: Medical Deductible Applies
Retail Participating Pharmacy (1 Copay per 30 day supply) *Copay is determined by tier as listed on the Anthem Select Drug list.*	Tiers 1-4: medical deductible applies.	All Tiers: 35% of covered expense up to $500 max per script after medical deductible	Tier 1a: $10 copay Tier 1b: $20 copay Tier 2: $60 copay Tier 3: $100 copay	Tier 1a: $5 copay Tier 1b: $20 copay Tier 2: $60 copay Tier 3: $100 copay	Tier 1a: $10 copay Tier 1b: $20 copay Tier 2: $60 copay Tier 3: $90 copay
Specialty Pharmacy Drugs (1 Copay per 30 day supply)	0% of covered expense after medical deductible	35% up to $500 max per script after medical deductible	Tier 4: 30% up to a max. $500 copay per prescription	Tier 4: 30% up to max. $500 copay per prescription	Tier 4: 30% up to max. $500 copay per prescription

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LUD: 10-30-18

Anthem Blue Cross

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California Association of REALTORS®

January - December 2019 Anthem Blue Cross of California

Silver PPO Medical Plans Benefit Summary (1)

RealCare Insurance Marketing Inc

Benefits shown are what YOU WILL PAY for Preferred Providers ONLY.
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Benefits for Non Preferred Providers are significantly reduced.

Plans offered by Anthem Blue Cross of California ***Small Group Prudent Buyer PPO Network***	**Silver PPO 2000/25% (3KJ5/3KF3)** **(SEE DEDUCTIBLE NOTES)** **HSA COMPATIBLE PLAN**	**Silver PPO 50/2000/40% (3KG5)**	**Silver PPO 55/1750/35% (3KH7)**	**Silver PPO 40/1500/40% (3KGV)**
Calendar Year Deductible	Individual (Self-Only) Coverage: $2,000 Individual within a family: $2,700 Family: $4,000	Individual: $2,000 Family: $4,000	Individual: $1,750 Family: $3,500	Individual: $1,500 Family: $3,000
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $6,000 Family: $12,000	Individual: $7,900 Family: $15,800	Individual: $7,700 Family: $15,400	Individual: $7,600 Family: $15,200
Office Visits (Primary Care/Specialist)	25% of covered expense after deductible	$50/$85 Copay	$55/$80 Copay	$40/$70 Copay
Preventive Care Services including physical exams and covered preventive screenings	No copay (deductible waived)	No copay (deductible waived)	No copay (deductible waived)	No copay (deductible waived)
Diagnostic Services Lab, X-Ray Imaging (MRI/CT/PET)	25% of cov. expense after ded. 25% of cov. expense after ded.	40% of cov. expense after ded. $100/service + 40% of cov. expense after ded.	35% of cov. expense after ded. $100/service + 35% of cov. expense after ded.	40% of cov. expense after ded. $100/service + 40% of cov. expense after ded.
Emergency Care Facility Doctor Services	25% coinsurance after ded.	$350 + 40% Coinsurance after ded.	$300 + 35% coinsurance after ded.	$250 + 40% Coinsurance after ded.
Ambulance	25% of covered expense after deductible	40% of covered expense after deductible	35% of covered expense after deductible	40% of covered expense after deductible
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	25% of covd. exp. after ded. 25% of covd. exp. after ded.	40% of covd. exp. after ded. 40% of covd. exp. after ded.	35% of covd. exp. after ded. 35% of covd. exp. after ded.	40% of covd. exp. after ded. 40% of covd. exp. after ded.
Outpatient Surgery Facility Fee Doctor Services	25% of covd. exp. after ded. 25% of covd. exp. after ded.	40% of covd. exp. after ded. 40% of covd. exp. after ded.	35% of covd. exp. after ded. 35% of covd. exp. after ded.	40% of covd. exp. after ded. 40% of covd. exp. after ded.
Prescription Drug Benefits				
Prescription Drug Deductible	Tiers 1-4: Medical deductible applies.	Tier 1: No Deductible Tiers 2-4: $150/$300 Pharmacy deductible	Tier 1: No Deductible Tiers 2-4: $300/$600 Pharmacy deductible	Tier 1: No Deductible Tiers 2-4: $400/$800 Pharmacy deductible
Retail Participating Pharmacy (1 Copay per 30 day supply) *Copay is determined by tier as listed on the Anthem Select Drug list.*	Tier 1a : $5 copay after med. ded. Tier 1b : $20 copay after med. ded. Tier 2 : $50 copay after med. ded. Tier 3 : $80 copay after med. ded.	Tier 1a: $10 copay Tier 1b: $20 copay Tier 2: $55 copay Tier 3: $95 copay	Tier 1a: $5 copay Tier 1b: $20 copay Tier 2: $50 copay Tier 3: $90 copay	Tier 1a: $5 copay Tier 1b: $20 copay Tier 2: $50 copay Tier 3: $90 copay
Specialty Pharmacy Drugs (1 Copay per 30 day supply)	Tier 4: 30% after medical deductible to max $250 copay per prescription	Tier 4: 30% up to max. $250 copay per prescription	Tier 4: 30% up to a max. $250 copay per prescription	Tier 4: 30% up to max. $250 copay per prescription

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California Association of REALTORS®

January - December 2019 Anthem Blue Cross of California

Silver & Bronze PPO Medical Plans Benefit Summary (1)

RealCare Insurance Marketing Inc

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Plans offered by Anthem Blue Cross of California *Small Group Prudent Buyer PPO Network*	**Gold PPO 35/1000/20% (3KGM)**	**Gold PPO 30/750/20% (3KGD)**	**Gold PPO 30/500/20% (3KFF)**	**Gold PPO 20/30% (3KF7)**	**Platinum PPO 15/250/10% (3KFX)**	**Platinum PPO 20/10% (3KHP)**
Calendar Year Deductible	Individual: $1,000 Family: $3,000	Individual: $750 Family: $2,250	Individual: $500 Family: $1,500	None	Individual: $250 Family: $750	None
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $7,000 Family: $14,000	Individual: $7,000 Family: $14,000	Individual: $6.800 Family: $13,600	Individual: $6,500 Family: $13,000	Individual: $3,800 Family: $7,600	Individual: $3,300 Family: $6,600
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED					
Office Visits (Primary Care/Specialist)	$35/$60 Copay	$30/$55 Copay	$30/$60 Copay	$20/$50 Copay	$15/$30 Copay	$20/$40 Copay
Preventive Care Services including physical exams and covered preventive screenings	No copay (deductible waived)	No copay (deductible waived)	No copay (deductible waived)	No copay (deductible waived)	No copay (deductible waived)	No copay (deductible waived)
Diagnostic Services Lab, X-Ray Imaging (MRI/CT/PET)	20% of cov. expense after ded. $100/service + 20% of cov. expense after ded.	20% of cov. expense after ded. $100/service + 20% of cov. expense after ded.	20% of cov. expense after ded. $100/service + 20% of cov. expense after ded.	30% of covered expense $100/service + 30% of cov. Expense	10% of cov. expense after ded. $100/service + 10% of cov. expense after ded.	10% of covered expense $100/service + 10% of cov. Expense
Emergency Care Facility Doctor Services	Deductible, then $250 and 20% coinsurance 20% of cov. expense after ded.	Deductible, then $250 and 20% coinsurance 20% of cov. expense after ded.	Deductible, then $250 and 20% coinsurance 20% of cov. expense after ded.	$250, then 30% coinsurance 30% of cov. expense	Deductible, then $250 and 10% coinsurance 10% of cov. expense after ded.	$150, then 10% coinsurance 10% of cov. expense after ded.
Ambulance	20% of covered expense after deductible	20% of covered expense after deductible	20% of cov. expense after ded.	30% of covered expense	10% of covered expense after deductible	10% of covered expense after deductible
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	Deductible, then 20% coinsurance. 20% of cov. expense after ded.	Deductible, then 20% coinsurance. 20% of cov. expense after ded.	Deductible, then 20% coinsurance. 20% of cov. expense after ded.	30% coinsurance 30% coinsurance	Deductible, then 10% coinsurance. 10% of cov. expense after ded.	10% coinsurance 10% of cov. expense after ded.
Outpatient Surgery Facility Fee Doctor Services	Deductible, then 20% coinsurance. 20% of cov. expense after ded.	Deductible, then 20% coinsurance. 20% of cov. expense after ded.	Deductible, then 20% coinsurance. 20% of cov. expense after ded.	30% coinsurance 30% coinsurance	Deductible, then 10% coinsurance. 10% of cov. expense after ded.	10% coinsurance. 10% of cov. expense after ded.
Prescription Drug Benefits	**Anthem Select Drug List**					
Prescription Drug Deductible	Tier 1: No deductible Tiers 2-4: $150/$300 Pharmacy deductible.	Tier 1: No deductible Tiers 2-4: $200/$500 Pharmacy deductible.	Tier 1: No deductible Tiers 2-4: $200/$500 Pharmacy deductible.	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible.	None	None
Retail Participating Pharmacy (1 Copay for each 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 1a : $5 copay Tier 1b : $20 copay Tier 2 : $40 copay Tier 3 : $80	Tier 1a : $5 copay Tier 1b : $20 copay Tier 2 : $40 copay Tier 3 : $80	Tier 1a : $5 copay Tier 1b : $20 copay Tier 2 : $40 copay Tier 3 : $80	Tier 1a : $5 copay Tier 1b : $20 copay Tier 2 : $40 copay Tier 3 : $80	Tier 1a : $5 copay Tier 1b : $15 copay Tier 2 : $35 copay Tier 3 : $70	Tier 1a : $5 copay Tier 1b : $15 copay Tier 2 : $35 copay Tier 3 : $70
Specialty Pharmacy Drugs (1 Copay for each 30 day supply)	Tier 4: 30% up to max. $250 copay per prescription	Tier 4: 30% up to max. $250 copay per prescription	Tier 4: 30% up to max. $250 copay per prescription	Tier 4: 30% up to max. $250 copay per prescription	Tier 4: 30% up to max. $250 copay per prescription	Tier 4: 30% up to max. $250 copay per prescription

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January - December 2019 Anthem Blue Cross of California
HMO Medical Plans Benefit Summary [1]

RealCare Insurance Marketing Inc

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Plans offered by Anthem Blue Cross of California CaliforniaCare Network	**Silver HMO 55/2250/40% (3KL7)**	**Silver HMO 55 (3KJR)**	**Gold HMO 25 (3KHF)**	**Gold HMO 35 (306V)**
Calendar Year Deductible	Individual: $2,250 Family: $4,500	None	None	None
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $7,900 Family: $15,800	Individual: $7,900 Family: $15,800	Individual: $5,500 Family: $11,000	Individual: $5,500 Family: $11,000
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED			
Office Visits (Primary Care/Specialist)	$55/$100 Copay	$55/$85 Copay	$25/$50 Copay	$35/$70 Copay
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)
Diagnostic Services Lab, X-Ray (in office) Imaging (MRI/CT/PET)	Lab $50/visit; X-Ray $75/visit (ded. waived) Imaging: $350/service	Lab $50/visit; X-Ray $75/visit Imaging: $350/service	Lab $25/visit; X-Ray $40/visit Imaging: $250/service	Lab $25/visit; X-Ray $40/visit Imaging: $250/service
Emergency Care Facility Doctor Services	Deductible, then $325 and 40% coinsurance. 40% of covered expense after deductible	$350	$250	$250
Ambulance	40% of covered expense after deductible	$150/trip	$150/trip	$150/trip
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	Deductible, then 40% coinsurance	$500 copay per day up to 4 days per admission.	$500 copay per day up to 3 days per admission.	$750 copay per day day up tp 3 days per admission.
Outpatient Surgery Facility Fee Doctor Services	Deductible, then 40% coinsurance.	$500	$300	$500.00
Prescription Drug Benefits	**Anthem Select Drug List**			
Prescription Drug Deductible	Tier 1: No deductible. Tiers 2-4: $150/$300 Pharmacy deductible.	Tier 1: No deductible. Tiers 2-4: $500/$1000 Pharmacy deductible	None	None
Retail Participating Pharmacy (1 Copay for each 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 1a: $5 Tier 1b: $20 Tier 2: $70 Tier 3: $110	Tier 1a: $5 Tier 1b: $20 Tier 2: $80 Tier 3: $110	Tier 1a: $5 copay Tier 1b: $15 copay Tier 2: $35 copay Tier 3: $70	Tier 1a: $5 Tier 1b: $20 Tier 2: $40 Tier 3: $80
Specialty Pharmacy Drugs (1 Copay for each 30 day supply)	Tier 4: 30% up to $250 per prescription	Tier 4: 30% up to $250 per prescription	Tier 4: 30% up to $250 copay per prescription	Tier 4: 30% up to $250 copay per prescription

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Notes that apply to ALL Plans:

* The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
* Coverage for Non-emergency ambulance service for Non-Network Providers is limited to $50,000 maximum benefit per occurrence.
* For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".
* For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to ca.sgplans.anthem.com/ca/le
* If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
* Your copays, coinsurance and deductible count toward your out of pocket amount.
* If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
* If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
* For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
* Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

Additional Notes for PPO Plans

* If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
* Your coinsurance and deductible count toward your out of pocket amount
* All medical services subject to a coinsurance are also subject to the annual medical deductible.

Additional Notes for HMO Plans

* If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.

Additional Notes for HSA Plans

* Your coinsurance and deductible count toward your out of pocket amount
* All medical services subject to a coinsurance are also subject to the annual medical deductible.
* Vision services are not subject to the annual deductible.

Special Notes for Silver PPO 2000/25% HSA (3KJ5/3KF3)

* The Silver PPO 2000/25% HSA (3KJ5/3KF3) plan is associated with two different Anthem contracts. Both plans must meet federal guidelines for deductibles to be qualified for use with HSA (Health Savings Accounts). Contract 3KJ5 applies to individuals enrolling on their own, with NO dependents. Under this plan, the individual deductible is $2,000. Contract 3KF3 applies to anyone who enrolls with another family member. Under this plan, the individual deductible is $2,700. Federal guidelines dictate that the minimum deductible for an HSA compatible family plan is $2,700. Anthem applies the individual deductible so that any one family member who meets the individual deductible of $2,700 will begin receiving benefits.