Anthem Blue Cross

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

California Association of REALTORS®

January - December 2020 Anthem Blue Cross of California

HSA Compatible 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% (52SM)**	**Bronze PPO 5000/45% (52SH)**	**Silver PPO 2000/30% (4HVU/4HW2)** (SEE DEDUCTIBLE NOTES)
	HSA COMPATIBLE PLAN	**HSA COMPATIBLE PLAN**	**HSA COMPATIBLE PLAN**
Calendar Year Deductible	Individual: $6,600 Family: $13,200	Individual: $5,000 Family: $10,000	Individual (Self-Only) Coverage: $2,000 Individual within a family: $2,800 Family: $4,000
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $6,600 Family: $13,200	Individual: $6,750 Family: $13,500	Individual: $6,500 Family: $13,000
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE EXCEPT PREVENTIVE CARE		
Office Visits (Primary Care/Specialist)	Deductible then 0%	Deductible then 45% of covered expense	Deducible then 30% of covered expense
Preventive Care Services including physical exams and covered preventive screenings	No copay (deductible waived)	No copay (deductible waived)	No copay (deductible waived)
Diagnostic Services (Office/Outpt. Hosp./Freestanding Lab) Lab, X-Ray Imaging (MRI/CT/PET)	 Deductible then 0% of covered expense Deductible then 0% of covered expense	 Deductible then 45% of covered expense Deductible then 45% of covered expense	 Deductible then 30% of covered expense Deductible then 30% of covered expense
Emergency Care Facility Doctor Services	 Deductible then 0% of covered expense Deductible then 0% of covered expense	 Deductible then 45% of covered expense Deductible then 45% of covered expense	 Deductible then 30% of covered expense Deductible then 30% of covered expense
Ambulance	Deductible then 0% of covered expense	Deductible then 45% of covered expense	Deductible then 30% of covered expense
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	 Deductible then 0% of covered expense Deductible then 0% of covered expense	 Deductible then 45% of covered expense Deductible then 45% of covered expense	 Deductible then 30% of covered expense Deductible then 30% of covered expense
Outpatient Surgery Facility Fee Doctor Services	 Deductible then 0% of covered expense Deductible then 0% of covered expense	 Deductible then 45% of covered expense Deductible then 45% of covered expense	 Deductible then 30% of covered expense Deductible then 30% of covered expense
Prescription Drug Benefits		**Anthem Select Drug List**	
Prescription Drug Deductible	Combined with Medical deductible	Combined with Medical deductible	Combined with Medical deductible
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: Deductible then 0% of covered expense	Tiers 1-4: Deductible then 35% of covered expense up to $500 max per script	Tier 1 : $20 copay after med. ded. Tier 2 : $55 copay after med. ded. Tier 3 : $80 copay after med. ded. Tier 4: 30% to $250 per script after med. Ded.

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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***	**Bronze PPO 70/6300/35% (4HY6)**	**NEW! Bronze PPO 3950/50% (4J08)**	**Bronze PPO 40/5600/40% (4HUE)**	**NEW! Bronze PPO 60/6350/40% (4HU5)**
Calendar Year Deductible	Individual: $6,300 Family: $12,600	Individual: $3,950 Family: $7,900	Individual: $5,600 Family: $11,200	Individual: $6,350 Family: $12,700
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $8,150 Family: $16,300	Individual: $8,100 Family: $16,200	Individual: $8,150 Family: $16,300	Individual: $8,150 Family: $16,300
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED			
Office Visits (Primary Care/Specialist)	$70/$85 for first 3 visits, then ded. and $70/$85	Deductible then 50% of covered expense	$40/$80 for first 3 visits, then ded. and $40/$80	$60/$80 for first 3 visits, then ded. and $60/$80
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 (Ofc / OP Hosp. / Freestanding Lab) Imaging (MRI/CT/PET)	 Deduct. then 35% of cov. expense Ded. then $100 + 35% of cov. expns	 Deduct. then 50% of cov. expense Deduct. then 50% of cov. expense	 Deduct. then 40% of cov. expense Ded. then $100 + 40% of cov. expns	 Deduct. then 40% of cov. expense Ded. then $100 + 40% of cov. expns
Emergency Care Facility Doctor Services	 Ded. then $200 + 35% of cov. expense Deductible + 35% of covered expense	 Deductible then 50% of covered expense Deductible then 50% of covered expense	 Ded. then $200 + 40% of cov. expense Deductible + 40% of covered expense	*(Pending verification)* Ded. then $350 + 40% of cov. expense Deductible + 40% of covered expense
Ambulance	Deduct. then 35% of cov. expense	Deduct. then 50% of cov. expense	Deduct. then 40% of cov. expense	Deduct. then 40% of cov. expense
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	 Deduct. then 35% of cov. expense Deduct. then 35% of cov. expense	 Deduct. then 50% of cov. expnse Deduct. then 50% of cov. expnse	 Deduct. then 40% of cov. expense Deduct. then 40% of cov. expense	 Deduct. then 40% of cov. expense Deduct. then 40% of cov. expense
Outpatient Surgery Facility Fee Doctor Services	 Deduct. then 35% of cov. expense Deduct. then 35% of cov. Expense	 Deduct. then 50% of cov. expnse Deduct. then 50% of cov. expnse	 Deduct. then 40% of cov. expense Deduct. then 40% of cov. expense	 Deduct. then 40% of cov. expense Deduct. then 40% of cov. expense
Prescription Drug Benefits	**Anthem Select Drug List**			
Prescription Drug Deductible	Tier 1: No Deductible Tiers 2-4: Medical Deductible Applies	Tiers 1-4: Medical Deductible Applies	Tier 1: No Deductible Tiers 2-4: Medical Deductible Applies	Tier 1: No Deductible Tiers 2-4: $625/$1,250 Rx Deductible
Retail Participating Pharmacy (1 Copay per 30 day supply) *Copay is determined by tier as listed on the Anthem Select Drug list.*	Tier 1: $20 copay Tier 2: $60 copay Tier 3: $100 copay Tier 4: 30% up to $500 per script	Tiers 1-4: Medical deductible applies, then 50% of covered expense to $500 per script	Tier 1: $20 copay Tier 2: $60 copay Tier 3: $100 copay Tier 4: 30% up to $500 per script	Tier 1: $20 copay Tier 2: $60 copay Tier 3: $100 copay Tier 4: 30% up to $500 per script

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Silver PPO Medical Plans Benefit Summary (1)

RealCare Insurance Marketing Inc

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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***	**NEW!** **Silver PPO 55/2500/45%** **(4J00)**	**Silver PPO 50/2000/40%** **(4HWY)**	**Silver PPO 55/1850/35%** **(4HY0)**	**Silver PPO 45/1750/40%** **(4HXN)**
Calendar Year Deductible	Individual: $2,500 Family: $5,000	Individual: $2,000 Family: $4,000	Individual: $1,850 Family: $3,700	Individual: $1,750 Family: $3,500
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $8,150 Family: $16,300	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)	$55/$85 Copay (deductible waived)	$50/$85 Copay (deductible waived)	$55/$85 Copay (deductible waived)	$45/$95 Copay (deductible waived)
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 (Ofc / Freestanding Lab) Lab, X-Ray (Outpat. Hospital) Imaging (MRI/CT/PET) (Outpat. Hosp.)	Lab Ofc/Freestndng Lab: $55 (Ded. wvd) Xray Ofc/Freestndg Lab: $85 (Ded. wvd) Lab/X-Ray Outpt. Hosp: Ded. + 45% of cov. expns. MRI/CT/PET: Ded. then $75 + 45% of cov. Expns.	Lab Ofc/Freestndng Lab: $50 (Ded. wvd) Xray Ofc/Freestndg Lab: $85 (Ded. wvd) Lab/X-Ray Outpt. Hosp: Ded. + 40% of cov. expns. MRI/CT/PET: Ded. then $100 + 40% of cov. Expns.	Lab Ofc/Freestndng Lab: $50 (Ded. wvd) Xray Ofc/Freestndg Lab: $85 (Ded. wvd) Lab/X-Ray Outpt. Hosp: Ded. + 35% of cov. expns. MRI/CT/PET: Ded. then $100 + 35% of cov. Expns.	Lab Ofc/Freestndng Lab: $45 (Ded. wvd) Xray Ofc/Freestndg Lab: $95 (Ded. wvd) Lab/X-Ray Outpt. Hosp: Ded. + 40% of cov. expns. MRI/CT/PET: Ded. then $100 + 40% of cov. Expns.
Emergency Care Facility Doctor Services	Ded. then $350 + 45% of cov. expense Deductible + 45% of covered expense	Ded then $350 + 40% of cov. expense Deductible + 40% of covered expense	Ded. then $350 + 35% of cov. expense Deductible + 35% of cov. expense	Ded. then $300 + 40% of cov. expense Deductible + 40% of covered expense
Ambulance	Deductible then 45% of covered expense	Deductible then 40% of covered expense	Deductible then 35% of covered expense	Deductible then 40% of covered expense
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	Deductible then 45% of covered expns. Deductible then 45% of covered expns.	Deductible then 40% of covered expns. Deductible then 40% of covered expns.	Deductible then 35% of covered expns. Deductible then 35% of covered expns.	Deductible then 40% of covered expns. Deductible then 40% of covered expns.
Outpatient Surgery Facility Fee Doctor Services	Deductible then 45% of covered expns. Deductible then 45% of covered expns.	Deductible then 40% of covered expns. Deductible then 40% of covered expns.	Deductible then 35% of covered expns. Deductible then 35% of covered expns.	Deductible then 40% of covered expns. Deductible then 40% of covered expns.
Prescription Drug Benefits	**Anthem Select Drug List**			
Prescription Drug Deductible	Tiers 1-4: No Deductible	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: $300/$600 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 1: $20 copay Tier 2: $60 copay Tier 3: $100 copay Tier 4: 30% to $250 per script	Tier 1: $20 copay Tier 2: $55 copay Tier 3: $95 copay Tier 4: 30% to $250 per script after ded.	Tier 1: $20 copay Tier 2: $50 copay Tier 3: $90 copay Tier 4: 30% to $250 per script after ded.	Tier 1: $20 copay Tier 2: $50 copay Tier 3: $90 copay Tier 4: 30% to $250 per script after ded.

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January - December 2020 Anthem Blue Cross of California

Gold & Platinum PPO Medical Plans Benefit Summary (1)

RealCare Insurance

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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***	**Gold PPO 35/1000/20% (4HXE)**	**Gold PPO 30/750/20% (4HX6)**	**Gold PPO 30/500/20% (4HWE)**	**Gold PPO 20/30% (4HW6)**	**Platinum PPO 15/250/10% (4HWQ)**	**Platinum PPO 20/10% (4HVH)**
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: $7,400 Family: $14,800	Individual: $7,400 Family: $14,800	Individual: $7, 250 Family: $14,500	Individual: $7,000 Family: $14,000	Individual: $4,000 Family: $8,000	Individual: $3,600 Family: $7,200
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED					
Office Visits (Primary Care/Specialist)	$35/$60 Copay (ded. waived)	$30/$55 Copay (ded. waived)	$30/$60 Copay (ded. waived)	$20/$50 Copay	$15/$30 Copay (ded. waived)	$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	No copay (deductible waived)	No copay
Diagnostic Services Lab, X-Ray (Ofc / Freestanding Lab) Lab, X-Ray (Outpat. Hospital) Imaging (MRI/CT/PET) (Outpat. Hosp.)	Lab Office: $35 (Ded. waived) Xray Office: $60 (Ded. waived) Ded. then 20% of covered expense MRI/CT/PET: Ded. then $100 + 20% of cov. expns.	Lab Office: $35 (Ded. waived) Xray Office: $55 (Ded. waived) Ded. then 20% of covered expense MRI/CT/PET: Ded. then $100 + 20% of cov. expns.	Lab Office: $30 (Ded. waived) Xray Office: $60 (Ded. waived) Ded. then 20% of covered expense MRI/CT/PET: Ded. then $100 + 20% of cov. expns.	Lab Office: $20 Xray Office: $50 30% of covered expense MRI/CT/PET: $100 + 30% of cov. expns.	Lab Office: $15 (Ded. waived) Xray Office: $30 (Ded. waived) Ded. then 10% of covered expense MRI/CT/PET: Ded. then $100 + 10% of cov. expns.	Lab Office: $20 Xray Office: $40 10% of covered expense MRI/CT/PET: $100 + 10% of cov. expns.
Emergency Care Facility Doctor Services	Deduct. then $250 + 20% of covd expns Deductible then 20% of covd expns	Deduct. then $250 + 20% of covd expns Deductible then 20% of covd expns	Deduct. then $250 + 20% of covd expns Deductible then 20% of covd expns	$250 + 30% of covd expns 30% of covd expns	Deduct. then $200 + 10% of covd expns Deductible then 10% of covd expns	$150 then 10% of covered expense 10% of covered expense
Ambulance	Deductible then 20% of covered expense	Deductible then 20% of covered expense	Deductible then 20% of covered expense	30% of covered expense	Deductible then 10% of covered expense	10% of covered expense
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	Deductible then 20% of covd expns. Deductible then 20% of covd expns.	Deductible then 20% of covd expns. Deductible then 20% of covd expns.	Deductible then 20% of covd expns. Deductible then 20% of covd expns.	30% of covered expense 30% of covered expense	Deductible then 10% of covd expns. Deductible then 10% of covd expns.	10% of covered expense 10% of covered expense
Outpatient Surgery Facility Fee Doctor Services	Deductible then 20% of covd expns. Deductible then 20% of covd expns.	Deductible then 20% of covd expns. Deductible then 20% of covd expns.	Deductible then 20% of covd expns. Deductible then 20% of covd expns.	30% of covered expense 30% of covered expense	Deductible then 10% of covd expns. Deductible then 10% of covd expns.	10% of covered expense 10% of covered expense
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: $250/$500 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $150/$300 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 1 : $15 copay Tier 2 : $40 copay Tier 3 : $80 copay Tier 4: 30% to $250 per script after ded.	Tier 1 : $15 copay Tier 2 : $40 copay Tier 3 : $80 copay Tier 4: 30% to $250 per script after ded.	Tier 1 : $15 copay Tier 2 : $40 copay Tier 3 : $80 copay Tier 4: 30% to $250 per script after ded.	Tier 1 : $15 copay Tier 2 : $40 copay Tier 3 : $80 copay Tier 4: 30% to $250 per script after ded.	Tier 1 : $10 copay Tier 2 : $35 copay Tier 3 : $70 copay Tier 4: 30% to $250 per script	Tier 1 : $10 copay Tier 2 : $35 copay Tier 3 : $70 copay Tier 4: 30% to $250 per script

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January - December 2020 Anthem Blue Cross of California
HMO Medical Plans Benefit Summary (1)

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Plans offered by Anthem Blue Cross of California CaliforniaCare Network	**Silver HMO 55/2250/45% (4HYF)**	**Silver HMO 55 (4HTA)**	**Gold HMO 35 (4HUV)**	**Gold HMO 30 (4HV5)**
Calendar Year Deductible	Individual: $2,250 Family: $4,500	None	None	None
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $8,150 Family: $16,300	Individual: $8,150 Family: $16,300	Individual: $6,000 Family: $12,000	Individual: $5,800 Family: $11,600
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED			
Office Visits (Primary Care/Specialist)	$55/$110 Copay (deductible waived)	$55/$110 Copay	$35/$70 Copay	$30/$55 Copay
Preventive Care Services including physical exams and covered preventive screenings	No Copay (deductible waived)	No Copay	No Copay	No Copay
Diagnostic Services (Office/Outpt. Hosp./Freestanding Lab) Lab, X-Ray Imaging (MRI/CT/PET)	Lab $55/visit (Ded. waived) X-Ray $90/visit (Ded. waived) Imaging: Deductible then $350/service	Lab $55/visit X-Ray $90/visit Imaging: $350/service	Lab $30/visit X-Ray $45/visit Imaging: $250/service	Lab $25/visit X-Ray $45/visit Imaging: $250/service
Emergency Care Facility Doctor Services	Deduct. then $350 + 45% of cov. expns. No charge	$450 Copay No charge	$300 Copay No Charge	$250 Copay No Charge
Ambulance	Deductible then 45% of covered expense	$150/trip	$150/trip	$150/trip
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	Deductible then 45% of covered expense	$600 copay/day up to 5 days/admission No charge	$750 copay/day up to 4 days/admission No charge	$600 copay/day up to 4 days/admission No charge
Outpatient Surgery Facility Fee Doctor Services	Deductible then 45% of covered expense *(Pending verification)*	$600 Copay No charge	$500 Copay No charge	$300 Copay No charge
Prescription Drug Benefits	**Anthem Select Drug List**			
Prescription Drug Deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $600/$1200 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 1: $20 copay Tier 2: $80 copay Tier 3: $110 copay Tier 4: 30% to $250 max per script	Tier 1: $20 copay Tier 2: $80 copay Tier 3: $110 copay Tier 4: 30% to $250 max per script	Tier 1: $15 copay Tier 2: $40 copay Tier 3: $80 copay Tier 4: 30% to $250 max per script	Tier 1: $15 copay Tier 2: $35 copay Tier 3: $70 copay Tier 4: 30% to $250 max per script

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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 air 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 2000/30% HSA (4HVU/4HW2)

* The Silver PPO 2000/30% HSA (4HVU/4HW2) 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 4HVU applies to individuals enrolling on their own, with NO dependents. Under this plan, the individual deductible is $2,000. Contract 4HW2 applies to anyone who enrolls with another family member. Under this plan, the individual deductible is $2,800. Federal guidelines dictate that the minimum deductible for an individual family member in an HSA compatible family plan is equal to the amount listed in federal regulation Title 26 or the individual deductible, whichever is greater. Anthem applies the individual deductible so that any one family member who meets the individual deductible of $2,800 will begin receiving benefits.