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 2021 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 6950/0% (5SU5)**	**Bronze PPO 5600/45% (5STX)**	**Silver PPO 2000/30% HSA - RxC (5SW5/5SWD)** (SEE DEDUCTIBLE NOTES)	**NEW! Silver PPO 2500/35% HSA (PrevRx) (5T0V/5T0Z)** (SEE DEDUCTIBLE NOTES)
	HSA COMPATIBLE PLAN	**HSA COMPATIBLE PLAN**	**HSA COMPATIBLE PLAN**	**HSA COMPATIBLE PLAN**
Calendar Year Deductible	Individual: $6,950 Family: $13,900	Individual: $5,600 Family: $11,200	Individual (Self-Only) Coverage: $2,000 Individual within a family: $2,800 Family: $4,000	Individual (Self-Only) Coverage: $2,500 Individual within a family: $2,800 Family: $5,000
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $6,950 Family: $13,900	Individual: $7,000 Family: $14,000	Individual: $6,750 Family: $13,500	Individual: $6,950 Family: $13,900
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE EXCEPT PREVENTIVE CARE			
Office Visits (Primary Care/Specialist)	Deductible then 0% of covered expense	Deductible then 45% of covered expense	Deducible then 30% of covered expense	Deducible then 35% of covered expense
Online doctor visits: LiveHealth Online	Deductible then 0% of covered expense	Deductible then 45% of covered expense	Deducible then 30% of covered expense	Deductible then 35% 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)	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 $75 + 45% of covered expense	 Deductible then 30% of covered expense Freestanding Lab: No copay after Ded. is met Deductible then $100 + 30% of covered expense	 Deductible then 35% of covered expense Freestanding Lab: No copay after Ded. is met Deductible then $100 + 35% 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	 Deductible then 35% of covered expense Deductible then 35% of covered expense
Ambulance	Deductible then 0% of covered expense	Deductible then 45% of covered expense	Deductible then 30% of covered expense	Deductible then 35% 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	 Deductible then 35% of covered expense Deductible then 35% of covered expense
Outpatient Surgery Facility Fee Doctor Services	 Deductible then 0% of covered expense Deductible then 0% of covered expense	 Deductible then $200 + 45% of covered expense Deductible then 45% of covered expense	 Deductible then $200 + 30% of covered expense Deductible then 30% of covered expense	 Deductible then $200 + 35% of covered expense Deductible then 35% 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	Combined with Medical deductible ‡
Retail Participating Pharmacy (1 Copay for each 30 day supply) *Copay is determined by pharmacy level and drug tier. Drug tier is listed on the tiered drug formulary list. For more information consult your physician or visit www.anthem.com/ca, click on Customer Care*	LEVEL 1: Deductible then 0% LEVEL 2: Deductible then 0%	LEVEL 1: 35% up to $500 per script LEVEL 2: 35% up to $500 per script	LEVEL 1: $20/$60/$85/30% to $250 per script LEVEL 2: $25/$95/$115/40% up to $250 per script	LEVEL 1: $20/$65/$100/30% to $250 per script LEVEL 2: $25/$100/$115/40% up to $250 per script

(1) Benefit Disclaimer: We do not guarantee or warrant the correctness or completeness of the benefit information contained herein and shall not be liable for any loss or damage arising out of use of the quoted benefit information. Additionally, information contained in this report is limited in scope, subject to change without notice, and does not contain all the terms, conditions, limitations, or exclusions of the referenced benefit plans. Only the insurance company Plan Documents and Policies contain the exact terms and conditions of coverage. This report may not be relied upon as a guarantee of your eligibility for coverage under these benefit plans. Benefits valid for plan year 1/1/21 to 12/31/21. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: www.RealCareCAR.com/notices

LUD: 10/27/20

Anthem Blue Cross

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

California Association of REALTORS®

January - December 2021 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 70/6600/35% (5SXL)**	**Bronze PPO 40/5600/40% (5SWH)**	**Bronze PPO 4600/50% (5SR9)**	**Bronze PPO 60/6350/40% (5SSR)**	**Bronze PPO 75/7300/40% (5T09)**
Calendar Year Deductible	Individual: $6,600 Family: $13,200	Individual: $5,600 Family: $11,200	Individual: $4,600 Family: $9,200	Individual: $6,350 Family: $12,700	Individual: $7,300 Family: $14,600
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $8,550 Family: $17,100	Individual: $8,400 Family: $16,800	Individual: $8,100 Family: $16,200	Individual: $8,150 Family: $16,300	Individual: $8,550 Family: $17,100
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED				
Office Visits (Primary Care/Specialist)	Deductible then $70/$85	Deductible then $40/$80	Deductible then 50% of covered expense	Deductible then $60/$80	$75/$110 Copay (deductible waived)
Online doctor visits: LiveHealth Online	$0 for first 12 visits, then $5	$0 for first 12 visits, then $5	Deductible then 50% of covered expense	$0 for first 12 visits, then $5	$0 for first 12 visits, then $5
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)
Diagnostic Services Lab, X-Ray (Ofc / OP Hosp. / Freestanding Lab) Imaging (MRI/CT/PET)	Deduct. then 35% of cov. expense Deduct. then 35% of cov. expense	Deduct. then 40% of cov. expense Deuct. then 40% of cov. Expense	Deduct. then 50% of cov. expense Deduct. then 50% of cov. expense	Deduct. then 40% of cov. expense Deduct. then 40% of cov. expense	$25 (Ded. Wvd) / No copay (Ded. Wvd)/ Ded. Then 40% of cov. Exps. Deduct. Then 40% of cov. expense
Emergency Care Facility Doctor Services	Ded. then $250 + 35% of cov. expense Deductible + 35% of covered expense	Ded. then $250 + 40% of cov. expense Deduct. then 40% of covered expense	Deductible then 50% of covered expense Deductible then 50% of covered expense	Ded. then $250 + 40% of cov. expense Deductible + 40% of covered expense	Ded. then $250 + 40% of cov. expense Deductible + 40% of covered expense
Ambulance	Deduct. then 35% of cov. expense	Deduct. then 40% 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 40% of cov. expense Deduct. then 40% 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 $200 + 35% of cov. expense Deduct. then 35% of cov. Expense	Deduct. then $200 + 40% of cov. expense Deduct. then 40% of cov. expense	Deduct. then 50% of cov. expnse Deduct. then 50% of cov. expnse	Deduct. then $200 + 40% of cov. expense Deduct. then 40% of cov. expense	Deduct. then $200 + 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	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: $625/$1,250 Rx Deductible	Tier 1: No Deductible Tiers 2-4: $750/$1,500 Rx Deductible
Retail Participating Pharmacy (1 Copay for each 30 day supply) *Copay is determined by pharmacy level and drug tier. Drug tier is listed on the tiered drug formulary list. For more information consult your physician or visit www.anthem.com/ca, click on Customer Care*	LEVEL 1: $20/$70/$110/30% to $500 per script LEVEL 2: $25/$115/$150/40% up to $500 per script	LEVEL 1: $20/$70/$110/30% to $500 per script LEVEL 2: $25/$115/$150/40% up to $500 per script	LEVEL 1: 40% up to $500 per script LEVEL 2: 50% up to $500 per script	LEVEL 1: $20/$65/$105/30% to $500 per script LEVEL 2: $25/$100/$140/40% up to $500 per script	LEVEL 1: $25/$115/$160/30% to $500 per script LEVEL 2: $25/$130/$180/40% up to $500 per script

(1) Benefit Disclaimer: We do not guarantee or warrant the correctness or completeness of the benefit information contained herein and shall not be liable for any loss or damage arising out of use of the quoted benefit information. Additionally, information contained in this report is limited in scope, subject to change without notice, and does not contain all the terms, conditions, limitations, or exclusions of the referenced benefit plans. Only the insurance company Plan Documents and Policies contain the exact terms and conditions of coverage. This report may not be relied upon as a guarantee of your eligibility for coverage under these benefit plans. Benefits valid for plan year 1/1/21 to 12/31/21. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: www.RealCareCAR.com/notices

LUD: 10/27/20

Anthem Blue Cross

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

California Association of REALTORS®

January - December 2021 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.
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***	**Silver PPO 55/2500/45% (5SR1)**	**Silver PPO 50/2200/40% (5SYL)**	**Silver PPO 55/1850/35% (2LHZ)**	**Silver PPO 45/1750/40% (5SZA)**
Calendar Year Deductible	Individual: $2,500 Family: $5,000	Individual: $2,200 Family: $4,400	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: $8,150 Family: $16,300	Individual: $8,500 Family: $17,000	Individual: $8,100 Family: $16,200
	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)
Online doctor visits: LiveHealth Online	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5
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. (Ofc. / Freestanding / Outpat. Hosp.) X-Ray (Ofc. / Freestanding & Outpat. Hosp.) Imaging (MRI/CT/PET) (Outpat. Hosp.)	$20 (Ded. Wvd) / No copay (Ded. Wvd)/ Ded. Then 45% of cov. Exps. $20 (Ded. wvd) / Ded. then 45% MRI/CT/PET: Ded. then $75 + 45% of cov. Expns.	$20 (Ded. Wvd) / No copay (Ded. Wvd)/ Ded. Then 40% of cov. Exps. $20 (Ded. wvd) / Ded. then 40% MRI/CT/PET: Ded. then $100 + 40% of cov. Expns.	$20 (Ded. Wvd) / No copay (Ded. Wvd)/ Ded. then 35% of cov. exps $20 (Ded. wvd) / Ded. then 35% MRI/CT/PET: Ded. then $100 + 35% of cov. Expns.	$20 (Ded. Wvd) / No copay (Ded. Wvd)/ Ded. Then 40% of cov. Exps. $20 (Ded. wvd) / Ded. then 40% MRI/CT/PET: Ded. then $100 + 40% of cov. Expns.
Emergency Care Facility Doctor Services	Ded. then $100 + 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 covered 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 $200 + 45% of covered expns. Deductible then 45% of covered expns.	Deductible then $200 + 40% of covered expns. Deductible then 40% of covered expns.	Deductible then $200 + 35% of covered expns. Deductible then 35% of covered expns.	Deductible then $200 + 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: $250/$500 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 for each 30 day supply) *Copay is determined by pharmacy level and drug tier. Drug tier is listed on the tiered drug formulary list. For more information consult your physician or visit www.anthem.com/ca, click on Customer Care*	LEVEL 1: $20/$65/$110/30% to $250 per script LEVEL 2: $25/$100/$140/40% up to $250 per script	LEVEL 1: $20/$60/$100/30% to $250 per script LEVEL 2: $25/$100/$140/40% up to $250 per script	LEVEL 1: $20/$60/$100/30% to $250 per script LEVEL 2: $25/$95/$140/40% up to $250 per script	LEVEL 1: $20/$60/$100/30% to $250 per script LEVEL 2: $25/$95/$140/40% up to $250 per script

(1) Benefit Disclaimer: We do not guarantee or warrant the correctness or completeness of the benefit information contained herein and shall not be liable for any loss or damage arising out of use of the quoted benefit information. A information contained in this report is limited in scope, subject to change without notice, and does not contain all the terms, conditions, limitations, or exclusions of the referenced benefit plans. Only the insurance company Plan Doc Policies contain the exact terms and conditions of coverage. This report may not be relied upon as a guarantee of your eligibility for coverage under these benefit plans. Benefits valid for plan year 1/1/21 to 12/31/21. For a detailed list and a copy of the Evidence of Coverage please visit: www.RealCareCAR.com/notices

LUD: 10/27/20

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 2021 Anthem Blue Cross of California

Gold and Platinum 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*	**Gold PPO 35/1000/20% (5SZ2)**	**Gold PPO 30/750/20% (5SYU)**	**Gold PPO 30/500/20% (5SY2)**	**Gold PPO 20/30% (5SXU)**	**Platinum PPO 15/250/10% (5SYC)**	**Platinum PPO 20/10% (5SVU)**
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: $7,800 Family: $15,600	Individual: $7,800 Family: $15,600	Individual: $7,500 Family: $15,000	Individual: $7,400 Family: $14,800	Individual: $4,000 Family: $8,000	Individual: $4,000 Family: $8,000
	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
Online doctor visits: LiveHealth Online	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5
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. (Ofc. / Freestanding / Outpat. Hosp.) X-Ray (Ofc. / Freestanding & Outpat. Hosp.) Imaging (MRI/CT/PET) (Outpat. Hosp.)	$15 (Ded. Wvd) / No copay (Ded. Wvd) / Ded. then 20% of cov. expns $15 (Ded. wvd) / Ded. then 20% MRI/CT/PET: Ded. then $100 + 20% of cov. Expns.	$15 (Ded. Wvd) / No copay (Ded. Wvd) / Ded. then 20% of cov. expns $15 (Ded. wvd) / Ded. then 20% MRI/CT/PET: Ded. then $100 + 20% of cov. Expns.	$15 (Ded. Wvd) / No copay (Ded. Wvd) / Ded. then 20% of cov. expns $15 (Ded. wvd) / Ded. then 20% MRI/CT/PET: Ded. then $100 + 20% of cov. Expns.	$15 copay / No copay then 30% of cov. expns. $15 copay / 30% MRI/CT/PET: Ded. then $100 + 30% of cov. Expns.	$10 (Ded. wvd) / No copy (Ded. wvd) / Ded. then 10% of cov. expns. $10 (Ded. wvd) / Ded. then 10% MRI/CT/PET: Ded. then $100 + 10% of cov. Expns.	$10 copay / No copy / 10% of cov. expns. $10 copay / 10% 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	$200 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 $200 + 20% of covd expns. Deductible then 20% of covd expns.	Deductible then $200 + 20% of covd expns. Deductible then 20% of covd expns.	Deductible then $200 + 20% of covd expns. Deductible then 20% of covd expns.	$200 then 30% of covered expense 30% of covered expense	Deductible then $200 + 10% of covd expns. Deductible then 10% of covd expns.	$150, then 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: $250/$500 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $200/$400 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 pharmacy level and drug tier. Drug tier is listed on the tiered drug formulary list. For more information consult your physician or visit www.anthem.com/ca, click on Customer Care*	LEVEL 1: $15/$45/$85/30% to $250 per script LEVEL 2: $25/$65/$95/40% up to $250 per script	LEVEL 1: $15/$45/$85/30% to $250 per script LEVEL 2: $25/$65/$95/40% up to $250 per script	LEVEL 1: $15/$45/$85/30% to $250 per script LEVEL 2: $25/$65/$95/40% up to $250 per script	LEVEL 1: $15/$45/$85/30% to $250 per script LEVEL 2: $25/$65/$95/40% up to $250 per script	LEVEL 1: $10/$35/$70/30% to $250 per script LEVEL 2: $20/$50/$85/40% up to $250 per script	LEVEL 1: $10/$35/$70/30% to $250 per script LEVEL 2: $20/$50/$85/40% up to $250 per script

(1) Benefit Disclaimer: We do not guarantee or warrant the correctness or completeness of the benefit information contained herein and shall not be liable for any loss or damage arising out of use of the quoted benefit information. Additionally, information contained in this report is limited in scope, subject to change without notice, and does not contain all the terms, conditions, limitations, or exclusions of the referenced benefit plans. Only the insurance company Plan Documents and Policies contain the exact terms and conditions of coverage. This report may not be relied upon as a guarantee of your eligibility for coverage under these benefit plans. Benefits valid for plan year 1/1/21 to 12/31/21. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: www.RealCareCAR.com/notices

LUD: 10/27/20

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

California Association of REALTORS®

January - December 2021 Anthem Blue Cross of California

HMO Medical Plans Benefit Summary (1)

RealCare Insurance Marketing Inc

Benefits shown are what YOU WILL PAY for Contracted Providers ONLY.
Benefits for Non Contracted Providers are not covered.
Benefits shown are always based on the Blue Cross covered expense.

Plans offered by Anthem Blue Cross of California CaliforniaCare Network	**Silver HMO 55/2250/45% (5SX8)**	**Silver HMO 55 (5ST7)**	**Gold HMO 35 (5SWW)**	**Gold HMO 30 (5SVG)**
Calendar Year Deductible	Individual: $2,250 Family: $4,500	None	None	None
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $8,400 Family: $16,800	Individual: $8,400 Family: $16,800	Individual: $6,500 Family: $13,000	Individual: $6,000 Family: $12,000
	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
Online doctor visits: LiveHealth Online	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5	$0 for first 3 visits, then $5
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) (Outpat. Hospital)	Lab $20/visit (Ded. waived)/Ded then 45%/no charge X-Ray $20/visit (Ded. waived)/Ded then 45%/no charge/no charge Imaging: Deductible then $350/service	Lab $20/visit/$55 copay/no charge X-Ray $20/visit/$90 copay/no charge Imaging: $350/service	Lab $15/visit/$30 copay/no charge X-Ray $15/visit/$45 copay/$15 copay Imaging: $250/service	Lab $15/visit/$25 copay/no charge X-Ray $15/visit/$45 copay/$15 copay 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	$300 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 No charge	$600 Copay No charge	$500 Copay No charge	$400 Copay No charge
Prescription Drug Benefits	**Anthem Select Drug List**			
Prescription Drug Deductible	Tier 1: No deductible Tiers 2-4: $300/$600 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $400/$800 Pharmacy deductible	None	None
Retail Participating Pharmacy (1 Copay for each 30 day supply) *Copay is determined by pharmacy level and drug tier. Drug tier is listed on the tiered drug formulary list. For more information consult your physician or visit www.anthem.com/ca, click on Customer Care*	LEVEL 1: $20/$85/$115/30% to $250 per script LEVEL 2: $25/$110/$165/40% up to $250 per script	LEVEL 1: $20/$85/$115/30% to $250 per script LEVEL 2: $25/$110/$165/40% up to $250 per script	LEVEL 1: $15/$40/$80/30% to $250 per script LEVEL 2: $25/$60/$90/40% up to $250 per script	LEVEL 1: $15/$40/$80/30% to $250 per script LEVEL 2: $25/$60/$90/40% up to $250 per script

(1) Benefit Disclaimer: We do not guarantee or warrant the correctness or completeness of the benefit information contained herein and shall not be liable for any loss or damage arising out of use of the quoted benefit information. Additionally, information contained in this report is limited in scope, subject to change without notice, and does not contain all the terms, conditions, limitations, or exclusions of the referenced benefit plans. Only the insurance company Plan Documents and Policies contain the exact terms and conditions of coverage. This report may not be relied upon as a guarantee of your eligibility for coverage under these benefit plans. Benefits valid for plan year 1/1/20 to 12/31/20. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: www.RealCareCAR.com/notices

LUD: 10/27/20

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 more plan information, please refer to the Summary of Benefits (SOB). To find a specific SOB visit plan-summaries.anthem.com/sobdps/.
* The entire provisions of benefits, limitations and exclusions can be found in the Combined Evidence of Coverage/Certificate.
* 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 (5SW5/5SWD) and Silver PPO 2500/35% HSA (5T0V/5T0Z)

* The Silver PPO 2000/30% HSA (5SW5/5SWD) & Silver PPO 2500/35% HSA (5T0V/5T0Z) plans have a different deductible amount if the subscriber is enrolled as self only or has enrolled dependents in the plan: $2,000 or $2,500/member for self-only coverage; $2,800/member and $4,000 or $5,000/family for family coverage. Plans comply with AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.