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

California Association of REALTORS®

January - December 2022 Anthem Blue Cross of California

HSA Compatible PPO Medical Plans Benefit Summary (1)

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 6700/0% HSA (PrevRx) (6BSK)** **HSA COMPATIBLE PLAN**	**Bronze PPO 6000/45% HSA (PrevRx) (6BS7)** **HSA COMPATIBLE PLAN**	**Silver PPO 2100/30% HSA (PrevRx) (6BNP/6BU0)** **(SEE DEDUCTIBLE NOTES)** **HSA COMPATIBLE PLAN**	**Silver PPO 2600/35% HSA (PrevRx) (6BJE/6BJN)** **(SEE DEDUCTIBLE NOTES)** **HSA COMPATIBLE PLAN**
Calendar Year Deductible	Individual: $6,700 Family: $13,400	Individual: $6,000 Family: $12,000	Individual (Self-Only) Coverage: $2,100 Individual within a family: $2,800 Family: $4,200	Individual (Self-Only) Coverage: $2,600 Individual within a family: $2,800 Family: $5,200
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $7,050 Family: $14,100	Individual: $7,050 Family: $14,100	Individual: $7,050 Family: $14,100	Individual: $7,050 Family: $14,100
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE EXCEPT PREVENTIVE CARE			
Office Visits (Primary Care/Specialist)	Deductible then 0% coinsurance	Deductible then 45% coinsurance	Deductible then 30% coinsurance	Deductible then 35% coinsurance
LiveHealth Online (PCP/Specialist)	Deductible then 0%/0% coinsurance	Deductible then 0%/45% coinsurance	Deductible then 0%/30% coinsurance	Deductible then 0%/35% coinsurance
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/Xray Office: Deductible then 0% coinsurance Freestanding: Deductible then 0% coinsurance	Lab/Xray Office: Deductible then 45% coinsurance Freestanding: Deductible then No charge	Lab/Xray Office: Deductible then 30% coinsurance Freestanding: Deductible then No charge	Lab/Xray Office: Deductible then 35% coinsurance Freestanding: Deductible then No charge
Lab, X-Ray (Outpat. Hospital)	Lab/X-Ray Outpt. Hosp: Ded. + 0% coinsurance	Lab/X-Ray Outpt. Hosp: Ded. + 45% coinsurance	Lab/X-Ray Outpt. Hosp: Ded. + 30% coinsurance	Lab/X-Ray Outpt. Hosp: Ded. + 35% coinsurance
Imaging (MRI/CT/PET) (Outpat. Hosp.)	MRI/CT/PET: Ded. then 0% coinsurance	MRI/CT/PET: Ded. then $75 + 45% coinsurance	MRI/CT/PET: Ded. then $100 + 30% coinsurance	MRI/CT/PET: Ded. then $100 + 35% coinsurance
Emergency Care Facility Doctor Services	Deductible then 0% coinsurance Deductible then 0% coinsurance	Deductible then 45% coinsurance Deductible then 45% coinsurance	Deductible then 30% coinsurance Deductible then 30% coinsurance	Deductible then 35% coinsurance Deductible then 35% coinsurance
Ambulance	Deductible then 0% coinsurance	Deductible then 45% coinsurance	Deductible then 30% coinsurance	Deductible then 35% coinsurance
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	Deductible then 0% coinsurance Deductible then 0% coinsurance	Deductible then 45% coinsurance Deductible then 45% coinsurance	Deductible then 30% coinsurance Deductible then 30% coinsurance	Deductible then 35% coinsurance Deductible then 35% coinsurance
Outpatient Surgery Facility Fee Doctor Services	Deductible then 0% coinsurance Deductible then 0% coinsurance	Deductible then $200 + 45% coinsurance Deductible then 45% coinsurance	Deductible then $200 + 30% coinsurance Deductible then 30% coinsurance	Deductible then $200 + 35% coinsurance Deductible then 35% coinsurance
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 tier 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*	PREV/RX: $20/$90 (deductible waived) LEVEL 1: $20/$90/$160/30% to $400 per script LEVEL 2: $20/$100/$170/40% up to $500 per script	PREV/RX: $20/$90 (deductible waived) LEVEL 1: $20/$90/$160/30% to $400 per script LEVEL 2: $20/$100/$170/40% up to $500 per script	PREV/RX: $15/$70 (deductible waived) LEVEL 1: $15/$70/$110/30% to $250 per script LEVEL 2: $20/$80/$120/40% up to $250 per script	PREV/RX: $15/$70 (deductible waived) LEVEL 1: $15/$70/$110/30% to $250 per script LEVEL 2: $20/$80/$120/40% up to $250 per script

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PPO Medical Plans Benefit Summary [(1)]

Benefits shown are what YOU WILL PAY for Preferred Providers ONLY.
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Plans offered by Anthem Blue Cross of California ***Small Group Prudent Buyer PPO Network***	**Bronze PPO 70/6600/35% (6BUR)**	**Bronze PPO 40/6200/40% (6BU4)**	**Bronze PPO 4600/50% (6BKW)**	**Bronze PPO 60/6850/40% (6BME)**	**Bronze PPO 75/7300/40% (6BJW)**
Calendar Year Deductible	Individual: $6,600 Family: $13,200	Individual: $6,200 Family: $12,400	Individual: $4,600 Family: $9,200	Individual: $6,850 Family: $13,700	Individual: $7,300 Family: $14,600
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $8,700 Family: $17,400	Individual: $8,700 Family: $17,400	Individual: $8,100 Family: $16,200	Individual: $8,200 Family: $16,400	Individual: $8,650 Family: $17,300
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED				
Office Visits (Primary Care/Specialist)	PCP: Deductible then $70 SPC: Deductible then $85	PCP: Deductible then $40 SPC: Deductible then $80	Deductible then 50% coinsurance	PCP: Deductible then $60 SPC: Deductible then $80	PCP: $75 SPC: $110
LiveHealth Online (PCP/Specialist)	$0 (ded. waived)/$85 after ded.	$0 (ded. waived)/$80 after ded.	Deductible then 0%/50% coinsurance	$0 (ded. waived)/$80 after ded.	$0/$110 (ded. 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)	No copay (deductible waived)
Diagnostic Services Lab, X-Ray (Ofc / Freestanding Lab)	Lab Office: Ded then 35% Lab Freestanding: No Charge X-Ray Office or Freestanding: Ded + 35% coinsurance	Lab Office: Ded then 40% Lab Freestanding: No Charge X-Ray Office or Freestanding: Ded + 40% coinsurance	Lab Office: Ded then 50% Lab Freestanding: Ded then 0% X-Ray Office: Ded then 50% coinsurance X-Ray Freestanding: Ded + 40% coinsurance	Lab Office: Ded then 40% Lab Freestanding: No Charge X-Ray Office or Freestanding: Ded + 40% coinsurance	Lab/Xray Office: $25 (Ded. waived) Lab Freestanding: No charge X-Ray Freestanding: Ded. + 40% coinsurance
Lab, X-Ray (Outpat. Hospital)	Lab/X-Ray Outpt. Hosp: Ded. + 35% coinsurance	Lab/X-Ray Outpt. Hosp: Ded. + 40% coinsurance	Lab/X-Ray Outpt. Hosp: Ded. then 50% coinsurance	Lab/X-Ray Outpt. Hosp: Ded. + 40% coinsurance	Lab/X-Ray Outpt. Hosp: Ded. + 40% coinsurance
Imaging (MRI/CT/PET) (Outpat. Hosp.)	MRI/CT/PET: Ded. then $100 + 35% coinsurance	MRI/CT/PET: Ded. then $100 + 40% coinsurance	MRI/CT/PET: Ded. then 50% coinsurance	MRI/CT/PET: Ded. then $100 + 40% coinsurance	MRI/CT/PET: Ded. then $100 + 40%
Emergency Care Facility Doctor Services	Ded. then $250 + 35% coinsurance Deductible + 35% coinsurance	Ded. then $250 + 40% coinsurance Deductible + 40% coinsurance	Deductible then 50% coinsurance Deductible then 50% coinsurance	Ded. then $250 + 40% coinsurance Deductible + 40% coinsurance	Ded. then $250 + 40% coinsurance Deductible + 40% coinsurance
Ambulance	Deduct. then 35% coinsurance	Deduct. then 40% coinsurance	Deduct. then 50% coinsurance	Deduct. then 40% coinsurance	Deduct. then 40% coinsurance
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	Deduct. then 35% coinsurance Deduct. then 35% coinsurance	Deduct. then 40% coinsurance Deduct. then 40% coinsurance	Deduct. then 50% coinsurance Deduct. then 50% coinsurance	Deduct. then 40% coinsurance Deduct. then 40% coinsurance	Deduct. then 40% coinsurance Deduct. then 40% coinsurance
Outpatient Surgery Facility Fee Doctor Services	Deduct. then $200 + 35% coinsurance Deduct. then 35% coinsurance	Deduct. then $200 + 40% coinsurance Deduct. then 40% coinsurance	Deduct. then 50% coinsurance Deduct. then 50% coinsurance	Deduct. then $200 + 40% coinsurance Deduct. then 40% coinsurance	Deduct. then $200 + 40% coinsurance Deduct. then 40% coinsurance
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: $650/$1,300 Rx Deductible	Tier 1: No Deductible Tiers 2-4: $650/$1,300 Rx Deductible
Retail Participating Pharmacy (1 Copay for each 30 day supply) *Copay is determined by pharmacy tier 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/$80/$120/30% up to $400 per script LEVEL 2: $20/$90/$130/40% up to $500 per script	LEVEL 1: $20/$80/$120/30% to $400 per script LEVEL 2: $20/$90/$130/40% up to $500 per script	LEVEL 1: $20/$80/$120/30% up to $400 per script LEVEL 2: $20/$90/$130/40% up to $500 per script	LEVEL 1: $20/$90/$160/30% up to $400 per script LEVEL 2: $20/$100/$170/40% up to $500 per script	LEVEL 1: $20/$90/$160/30% up to $400 per script LEVEL 2: $20/$100/$170/40% up to $500 per script

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Plans offered by Anthem Blue Cross of California ***Small Group Prudent Buyer PPO Network***	**Silver PPO 55/2500/45% (6BKJ)**	**Silver PPO 50/2200/40% (6BPK)**	**Silver PPO 55/1950/35% (6BQV)**	**Silver PPO 45/1750/40% (6BQD)**
Calendar Year Deductible	Individual: $2,500 Family: $5,000	Individual: $2,200 Family: $4,400	Individual: $1,950 Family: $3,900	Individual: $1,750 Family: $3,500
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $8,700 Family: $17,400	Individual: $8,600 Family: $17,200	Individual: $8,700 Family: $17,400	Individual: $8,500 Family: $17,000
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED			
Office Visits (Primary Care/Specialist)	$55/$90 Copay (deductible waived)	$50/$90 Copay (deductible waived)	$55/$90 Copay (deductible waived)	$45/$95 Copay (deductible waived)
LiveHealth Online (PCP/Specialist)	$0/$90 Copay (deductible waived)	$0/$90 Copay (deductible waived)	$0/$90 Copay (deductible waived)	$0/$95 (ded. 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/Xray Office: $20 (Ded. waived) Lab Freestanding: No charge X-Ray Freestanding: Ded. +45% coinsurance Lab/X-Ray Outpt. Hosp: Ded. + 45% coinsurance MRI/CT/PET: Ded. then $75 + 45% coinsurance	Lab/Xray Office: $20 (Ded. waived) Lab Freestanding: No charge X-Ray Freestanding: Ded. + 40% coinsurance Lab/X-Ray Outpt. Hosp: Ded. + 40% coinsurance MRI/CT/PET: Ded. then $100 + 40% coinsurance	Lab/Xray Office: $20 (Ded. waived) Lab Freestanding: No charge X-Ray Freestanding: Ded. + 35% coinsurance Lab/X-Ray Outpt. Hosp: Ded. + 35% coinsurance MRI/CT/PET: Ded. then $100 + 35% coinsurance	Lab/Xray Office: $20 (Ded. waived) Lab Freestanding: No charge X-Ray Freestanding: Ded. + 40% coinsurance Lab/X-Ray Outpt. Hosp: Ded. + 40% coinsurance MRI/CT/PET: Ded. then $100 + 40% coinsurance
Emergency Care Facility Doctor Services	Ded. then $100 + 45% coinsurance Deductible + 45% coinsurance	Ded then $350 + 40% coinsurance Deductible + 40% coinsurance	Ded. then $350 + 35% coinsurance Deductible + 35% coinsurance	Ded. then $300 + 40% coinsurance Deductible + 40% coinsurance
Ambulance	Deductible then 45% coinsurance	Deductible then 40% coinsurance	Deductible then 35% coinsurance	Deductible then 40% coinsurance
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	Deductible then 45% coinsurance Deductible then 45% coinsurance	Deductible then 40% coinsurance Deductible then 40% coinsurance	Deductible then 35% coinsurance Deductible then 35% coinsurance	Deductible then 40% coinsurance Deductible then 40% coinsurance
Outpatient Surgery Facility Fee Doctor Services	Deductible then $200 + 45% coinsurance Deductible then 45% coinsurance	Deductible then $200 + 40% coinsurance Deductible then 40% coinsurance	Deductible then $200 + 35% coinsurance Deductible then 35% coinsurance	Deductible then $200 + 40% coinsurance Deductible then 40% coinsurance
Prescription Drug Benefits	**Anthem Select Drug List**			
Prescription Drug Deductible	Tier 1: No Deductible Tiers 2-4: $200/$400 Pharmacy deductible	Tier 1: No Deductible Tiers 2-4: $300/$600 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 tier 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/$70/$110/30% to $250 per script LEVEL 2: $20/$80/$120/40% up to $250 per script	LEVEL 1: $15/$70/$110/30% to $250 per script LEVEL 2: $20/$80/$120/40% up to $250 per script	LEVEL 1: $15/$70/$110/30% to $250 per script LEVEL 2: $20/$80/$120/40% up to $250 per script	LEVEL 1: $15/$70/$110/30% to $250 per script LEVEL 2: $20/$80/$120/40% up to $250 per script

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PPO Medical Plans Benefit Summary [1]

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Plans offered by Anthem Blue Cross of California ***Small Group Prudent Buyer PPO Network***	**Gold PPO 35/1000/20% (6BQ1)**	**Gold PPO 30/750/20% (6BPT)**	**Gold PPO 30/500/20% (6BP1)**	**Gold PPO 25/30% (6BNT)**	**Platinum PPO 15/250/10% (6BPB)**	**Platinum PPO 15/40/10% (6BNC)**
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: $8,200 Family: $16,400	Individual: $8,200 Family: $16,400	Individual: $7,900 Family: $15,800	Individual: $8,200 Family: $16,400	Individual: $4,200 Family: $8,400	Individual: $4,200 Family: $8,400
	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)	$25/$50 Copay	$15/$30 Copay (ded. waived)	$15/$40 Copay
LiveHealth Online (PCP/Specialist)	$0/$60 (ded. waived)	$0/$55 (ded. waived)	$0/$60 (ded. waived)	$0/$50	$0/$30 (ded. waived)	$0/$40
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/XRay Office: $15 Copay (ded. waived) Lab Freestanding: No Charge Xray Freestanding: Ded. Then 20% Lab/X-Ray Outpt. Hosp: Ded. then 20% coinsurance MRI/CT/PET: Ded. then $100 + 20% coinsurance	Lab/XRay Office: $15 Copay (ded. waived) Lab Freestanding: No Charge Xray Freestanding: Ded. Then 20% Lab/X-Ray Outpt. Hosp: Ded. then 20% coinsurance MRI/CT/PET: Ded. then $100 + 20% coinsurance	Lab/XRay Office: $15 Copay (ded. waived) Lab Freestanding: No Charge Xray Freestanding: Ded. Then 20% Lab/X-Ray Outpt. Hosp: Ded. then 20% coinsurance MRI/CT/PET: Ded. then $100 + 20% coinsurance	Lab/XRay Office: $15 Copay Lab Freestanding: No Charge Xray Freestanding: 30% coinsurance Lab/X-Ray Outpt. Hosp: 30% coinsurance MRI/CT/PET: Ded. then $100 + 30% coinsurance	Lab/XRay Office: $10 Copay (ded. waived) Lab Freestanding: No Charge Xray Freestanding: Ded then 10% Lab/X-Ray Outpt. Hosp: Ded then 10% MRI/CT/PET: Ded. then $100 + 10% coinsurance	Lab/Xray Office: $10 Copay Lab Freestanding: No charge Xray Freestanding: 10% coinsurance Lab/X-Ray Outpt. Hosp: 10% coinsurance MRI/CT/PET: $100 + 10% coinsurance
Emergency Care Facility Doctor Services	Deduct. then $250 + 20% coinsurance Deductible then 20% coinsurance	Deduct. then $250 + 20% coinsurance Deductible then 20% coinsurance	Deduct. then $250 + 20% coinsurance Deductible then 20% coinsurance	$250 + 30% coinsurance 30% coinsurance	Deduct. then $225 + 10% coinsurance Deductible then 10% coinsurance	$200 + 10% coinsurance 10% coinsurance
Ambulance	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Deductible then 20% coinsurance	30% coinsurance	Deductible then 10% coinsurance	10% coinsurance
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	Deductible then 20% coinsurance Deductible then 20% coinsurance	Deductible then 20% coinsurance Deductible then 20% coinsurance	Deductible then 20% coinsurance Deductible then 20% coinsurance	30% coinsurance 30% coinsurance	Deductible then 10% coinsurance Deductible then 10% coinsurance	10% coinsurance 10% coinsurance
Outpatient Surgery Facility Fee Doctor Services	Deductible then $200 + 20% coinsurance Deductible then 20% coinsurance	Deductible then $200 + 20% coinsurance Deductible then 20% coinsurance	Deductible then $200 + 20% coinsurance Deductible then 20% coinsurance	$200 + 30% coinsurance 30% coinsurance	Deductible then $200 + 10% coinsurance Deductible then 10% coinsurance	$150 + 10% coinsurance 10% coinsurance
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: $250/$500 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $150/$300 Pharmacy deductible	Tier 1: No Deductible Tiers 2-4: $150/$300	None	None
Retail Participating Pharmacy (1 Copay for each 30 day supply) *Copay is determined by pharmacy tier 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: $5/$60/$110/30% to $250 per script LEVEL 2: $15/$70/$120/40% up to $250 per script	LEVEL 1: $10/$50/$90/30% up to $250 per script LEVEL 2: $20/$60/$100/40% up to $250 per script	LEVEL 1: $10/$50/$90/30% to $250 per script LEVEL 2: $20/$60/$100/40% up to $250 per script	LEVEL 1: $10/$50/$90/30% up to $250 per script LEVEL 2: $20/$60/$100/40% up to $250 per script	LEVEL 1: $5/$35/$70/30% up to $250 per script LEVEL 2: $15/$45/$80/40% up to $250 per script	LEVEL 1: $5/$35/$70/30% up to $250 per script LEVEL 2: $15/$45/$80/40% up to $250 per script

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RealCare INSURANCE MARKETING INC

January - December 2022 Anthem Blue Cross of California
HMO Medical Plans Benefit Summary (1)

Benefits shown are what YOU WILL PAY for Contracted Providers ONLY.
Benefits for Non Contracted Providers are not covered.
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Plans offered by Anthem Blue Cross of California **CaliforniaCare Network**	**Silver HMO 60/2500/45%** **(6BRT)**	**Silver HMO 55** **(6BQZ)**	**Gold HMO 35** **(6BUH)**	**Gold HMO 30** **(6BN0)**
Calendar Year Deductible	Individual: $2,500 Family: $5,000	None	None	None
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: $8,700 Family: $17,400	Individual: $8,700 Family: $17,400	Individual: $6,750 Family: $13,500	Individual: $6,250 Family: $12,500
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED			
Office Visits (Primary Care/Specialist)	$60/$110 Copay (deductible waived)	$55/$110 Copay	$35/$75 Copay	$30/$60 Copay
LiveHealth Online (PCP/Specialist)	$0/$110	$0/$110	$0/$70	$0/$60
Preventive Care Services including physical exams and covered preventive screenings	No Copay (deductible waived)	No Copay	No Copay	No Copay
Diagnostic Services Lab	Lab Office: $20 Copay Lab Freestanding: No charge Lab Outpt. Hosp: Ded then 45%	Lab Office: $20 Copay Lab Freestanding: No charge Lab Outpt. Hosp: $55 Copay	Lab Office: $15 Copay Lab Freestanding: No charge Lab Outpt. Hosp: $30 Copay	Lab Office: $15 Copay Lab Freestanding: No charge Lab Outpt. Hosp: $25 Copay
X-Ray	X-Ray Office: $20 Copay X-Ray Freestanding: $20 Copay X-Ray Outpt. Hosp: Ded then 45%	X-Ray Office: $20 Copay X-Ray Freestanding: $20 Copay X-Ray Outpt. Hosp: $90 Copay	X-Ray Office: $15 Copay X-Ray Freestanding: $15 Copay X-Ray Outpt. Hosp: $45 Copay	X-Ray Office; $15 Copay X-Ray Freestanding: $15 Copay X-Ray Outpt. Hosp: $45 Copay
Imaging (MRI/CT/PET) (Outpat. Hosp.)	MRI/CT/PET: Office or Freestanding Radiology $200; Outpatient Hospital Ded then $350 Copay	MRI/CT/PET: Office or Freestanding Radiology $200; Outpatient Hospital $350	MRI/CT/PET: Office or Freestanding Radiology $100; Outpatient Hospital $250	MRI/CT/PET: Office or Freestanding Radiology $100; Outpatient Hospital $250
Emergency Care Facility Doctor Services	Deduct. then $350 + 45% coinsurance No charge	$500 Copay No charge	$325 Copay No Charge	$325 Copay No Charge
Ambulance	Deductible then 45% coinsurance	$150/trip	$150/trip	$150/trip
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	Deductible then 45% coinsurance No Charge	$650 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 (at hospital) Facility Fee Doctor Services	Deductible then 45% coinsurance No Charge	$600 Copay No charge	$550 Copay No charge	$450 Copay No charge
Prescription Drug Benefits	**Anthem Select Drug List**			
Prescription Drug Deductible	Tier 1: No deductible Tiers 2-4: $200/$400 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 tier 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/$70/$110/30% to $250 per script LEVEL 2: $20/$80/$120/40% up to $250 per script	LEVEL 1: $15/$90/$120/30% to $250 per script LEVEL 2: $20/$100/$130/40% up to $250 per script	LEVEL 1: $10/$50/$90/30% to $250 per script LEVEL 2: $20/$60/$100/40% up to $250 per script	LEVEL 1: $10/$50/$90/30% to $250 per script LEVEL 2: $20/$60/$100/40% 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 1/1/22 to 12/31/22. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: www.RealCareCAR.com/notices

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 both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both 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.
* If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
* For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
* If services are rendered by a non-participating provider and your plan includes out of network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider's 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.
* Certain services are subject to the utilization review program or precertification. Before scheduling services, the member must make sure utilization or precertification review is obtained. If utilization or precertification review is not obtained, benefits may be reduced or not paid according to the plan.
* Benefit period refers to calendar year.
* If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
* Your copays, coinsurance and deductible count toward your out of pocket amount.
* All medical and pharmacy deductibles, copayments and coinsurance apply to the out of pocket maximum.
* This health plan includes an Employee Assistance Program (EAP) with Emotional Wellbeing Resources to support your emotional health and wellness with resources including one-on-one counseling by phone, in person and online, virtual visits through LiveHealth Online. Three visits are provided at no charge and 24/7, 365 days of support on the go.
* Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.

Additional Notes for HMO Plans

* Your plan requires the selection of a Primary Care Physician (PCP). Choosing a PCP is an important decision. Call Anthem at the number on your ID card for help picking a doctor.
* Additionally, a referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services.

Additional Notes for HSA Plans

* Vision services are not subject to the annual deductible.

Special Notes for Silver HSA Plans

* The Silver PPO HSA Plans each have two different Anthem contracts (one for Single, one for Family). All plans must meet federal guidelines for deductibles to be qualified for use with HSA (Health Savings Accounts). Contract codes 6BNP and 6BJE apply to individuals enrolling on their own, with NO dependents. Under these plans, the only the individual deductible applies. Contracts 6BU0 and 6BJN apply to anyone who enrolls with another family member. Under these plans, the individual deductible applies to any one individual within the family. 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 will begin receiving benefits.