



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

California Association of REALTORS®

January - December 2023 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) (6RG7)	Bronze PPO 6000/45% HSA (PrevRx) (6RJK)	Silver PPO 2100/30% HSA (PrevRx) (6RK0/6RJ5) (SEE DEDUCTIBLE NOTES)	Silver PPO 2600/35% HSA (PrevRx) (6RG5/6RH6) (SEE DEDUCTIBLE NOTES)
	HSA COMPATIBLE PLAN	HSA COMPATIBLE PLAN	HSA COMPATIBLE PLAN	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: \$3,000 Family: \$4,200	Individual (Self-Only) Coverage: \$2,600 Individual within a family: \$3,000 Family: \$5,200
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: \$7,050 Family: \$14,100	Individual: \$7,050 Family: \$14,100	Individual: \$7,200 Family: \$14,400	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⁾



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<i>Plans offered by Anthem Blue Cross of California Small Group Prudent Buyer PPO Network</i>	Bronze PPO 70/6600/35% (6RFV)	Bronze PPO 40/6200/40% (6RJN)	Silver PPO 55/2500/45% (6RFY)	Silver PPO 50/2200/40% (6RK6)	Silver PPO 55/1950/35% (6RJ0)	Silver PPO 45/1750/40% (6RGX)
Calendar Year Deductible	Individual: \$6,600 Family: \$13,200	Individual: \$6,200 Family: \$12,400	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: \$8,700 Family: \$17,400	Individual: \$8,700 Family: \$17,400	Individual: \$8,600 Family: \$17,200	Individual: \$9,100 Family: \$18,200	Individual: \$9,100 Family: \$18,200
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	\$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 (ded. waived)/\$85 after ded.	\$0 (ded. waived)/\$80 after ded.	\$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)	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/Xray Office: \$20 (Ded. waived) Lab Freestanding: No charge X-Ray Freestanding: Ded. +45% coinsurance Lab/X-Ray Outpt. Hosp: Ded. + 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	Lab/Xray Office: \$20 (Ded. waived) Lab Freestanding: No charge X-Ray Freestanding: Ded. + 35% coinsurance Lab/X-Ray Outpt. Hosp: Ded. + 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
Lab, X-Ray (Outpat. Hospital)	Lab/X-Ray Outpt. Hosp: Ded. + 35% 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 \$75 + 45% coinsurance	MRI/CT/PET: Ded. then \$100 + 40% coinsurance	MRI/CT/PET: Ded. then \$100 + 35% coinsurance	MRI/CT/PET: Ded. then \$100 + 40% coinsurance
Emergency Care						
Facility	Ded. then \$250 + 35% coinsurance	Ded. then \$250 + 40% coinsurance	Ded. then \$100 + 45% coinsurance	Ded then \$350 + 40% coinsurance	Ded. then \$350 + 35% coinsurance	Ded. then \$300 + 40% coinsurance
Doctor Services	Deductible + 35% coinsurance	Deductible + 40% coinsurance	Deductible + 45% coinsurance	Deductible + 40% coinsurance	Deductible + 35% coinsurance	Deductible + 40% coinsurance
Ambulance	Deduct. then 35% coinsurance	Deduct. then 40% coinsurance	Deductible then 45% coinsurance	Deductible then 40% coinsurance	Deductible then 35% coinsurance	Deductible then 40% coinsurance
Hospital Stay						
Inpatient Facility Fees (Room & Board)	Deduct. then 35% coinsurance	Deduct. then 40% coinsurance	Deductible then 45% coinsurance	Deductible then 40% coinsurance	Deductible then 35% coinsurance	Deductible then 40% coinsurance
Doctor and other services	Deduct. then 35% coinsurance	Deduct. then 40% coinsurance	Deductible then 45% coinsurance	Deductible then 40% coinsurance	Deductible then 35% coinsurance	Deductible then 40% coinsurance
Outpatient Surgery						
Facility Fee	Deduct. then \$200 + 35% coinsurance	Deduct. then \$200 + 40% coinsurance	Deductible then \$200 + 45% coinsurance	Deductible then \$200 + 40% coinsurance	Deductible then \$200 + 35% coinsurance	Deductible then \$200 + 40% coinsurance
Doctor Services	Deduct. then 35% coinsurance	Deduct. then 40% coinsurance	Deductible then 45% coinsurance	Deductible then 40% coinsurance	Deductible then 35% coinsurance	Deductible 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: \$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: \$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: \$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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Plans offered by Anthem Blue Cross of California Small Group Prudent Buyer PPO Network	Gold PPO 35/1000/20% (6RH1)	Gold PPO 30/750/20% (6RG5)	Gold PPO 30/500/20% (6RG9)	Gold PPO 25/30% (6RFN)	Platinum PPO 15/250/10% (6RG6)	Platinum PPO 15/40/10% (6RH4)
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: \$3,800 Family: \$7,600	Individual: \$3,800 Family: \$7,600
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/XRay Office: \$15 Copay (ded. waived) Lab Freestanding: No Charge Xray Freestanding: Ded. Then 20%	Lab/XRay Office: \$15 Copay (ded. waived) Lab Freestanding: No Charge Xray Freestanding: Ded. Then 20%	Lab/XRay Office: \$15 Copay (ded. waived) Lab Freestanding: No Charge Xray Freestanding: Ded. Then 20%	Lab/XRay Office: \$15 Copay Lab Freestanding: No Charge Xray Freestanding: 30% coinsurance	Lab/XRay Office: \$10 Copay (ded. waived) Lab Freestanding: No Charge Xray Freestanding: Ded then 10%	Lab/Xray Office: \$10 Copay Lab Freestanding: No charge Xray Freestanding: 10% coinsurance
Lab, X-Ray (Outpat. Hospital)	Lab/X-Ray Outpt. Hosp: Ded. then 20% coinsurance	Lab/X-Ray Outpt. Hosp: Ded. then 20% coinsurance	Lab/X-Ray Outpt. Hosp: Ded. then 20% coinsurance	Lab/X-Ray Outpt. Hosp: 30% coinsurance	Lab/X-Ray Outpt. Hosp: Ded then 10%	Lab/X-Ray Outpt. Hosp: 10% coinsurance
Imaging (MRI/CT/PET) (Outpat. Hosp.)	MRI/CT/PET: Ded. then \$100 + 20% coinsurance	MRI/CT/PET: Ded. then \$100 + 20% coinsurance	MRI/CT/PET: Ded. then \$100 + 20% coinsurance	MRI/CT/PET: \$100 + 30% coinsurance	MRI/CT/PET: Ded. then \$100 + 10% coinsurance	MRI/CT/PET: \$100 + 10% coinsurance
Emergency Care						
Facility	Deduct. then \$250 + 20% coinsurance	Deduct. then \$250 + 20% coinsurance	Deduct. then \$250 + 20% coinsurance	\$250 + 30% coinsurance	Deduct. then \$225 + 10% coinsurance	\$200 + 10% coinsurance
Doctor Services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Deductible then 20% coinsurance	30% coinsurance	Deductible then 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)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Deductible then 20% coinsurance	30% coinsurance	Deductible then 10% coinsurance	10% coinsurance
Doctor and other services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Deductible then 20% coinsurance	30% coinsurance	Deductible then 10% coinsurance	10% coinsurance
Outpatient Surgery						
Facility Fee	Deductible then \$200 + 20% coinsurance	Deductible then \$200 + 20% coinsurance	Deductible then \$200 + 20% coinsurance	\$200 + 30% coinsurance	Deductible then \$200 + 10% coinsurance	\$150 + 10% coinsurance
Doctor Services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Deductible then 20% coinsurance	30% coinsurance	Deductible then 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	None	None	None	None
Retail Participating Pharmacy (1 Copay for each 30 day supply) <i>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</i>	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/\$30/\$50/30% up to \$250 per script LEVEL 2: \$15/\$40/\$60/40% up to \$250 per script	LEVEL 1: \$5/\$30/\$50/30% up to \$250 per script LEVEL 2: \$15/\$40/\$60/40% up to \$250 per script

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 PPO Medical Plans Benefit Summary ⁽¹⁾**

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 Benefits for Non Contracted Providers are not covered.
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Plans offered by Anthem Blue Cross of California CaliforniaCare Network	Silver HMO 55 (6RJG)	Gold HMO 35 (6RHZ)
Calendar Year Deductible	None	None
Annual Out of Pocket Maximum (Includes annual deductible)	Individual: \$9,100 Family: \$18,200	Individual: \$6,750 Family: \$13,500
ALL BENEFITS SHOW YOUR COPAY OR RESPONSIBILITY		
Office Visits (Primary Care/Specialist)	\$55/\$110 Copay	\$35/\$70 Copay
LiveHealth Online (PCP/Specialist)	\$0/\$110	\$0/\$70
Preventive Care Services including physical exams and covered preventive screenings	No Copay	No Copay
Diagnostic Services Lab X-Ray Imaging (MRI/CT/PET) (Outpat. Hosp.)	Lab Office: \$20 Copay Lab Freestanding: No charge Lab Outpt. Hosp: \$55 Copay X-Ray Office: \$20 Copay X-Ray Freestanding: \$40 Copay X-Ray Outpt. Hosp: \$90 Copay MRI/CT/PET: Office or Freestanding Radiology \$200; Outpatient Hospital \$350	Lab Office: \$15 Copay Lab Freestanding: No charge Lab Outpt. Hosp: \$30 Copay X-Ray Office: \$15 Copay X-Ray Freestanding: \$15 Copay X-Ray Outpt. Hosp: \$45 Copay MRI/CT/PET: Office or Freestanding Radiology \$100; Outpatient Hospital \$250
Emergency Care Facility Doctor Services	\$500 Copay No charge	\$325 Copay No Charge
Ambulance	\$150/trip	\$150/trip
Hospital Stay Inpatient Facility Fees (Room & Board) Doctor and other services	\$750 copay/day up to 5 days/admission No charge	\$750 copay/day up to 4 days/admission No charge
Outpatient Surgery (at hospital) Facility Fee Doctor Services	\$600 Copay No charge	\$550 Copay No charge
Prescription Drug Benefits	Anthem Select Drug List	
Prescription Drug Deductible	Tier 1: No deductible Tiers 2-4: \$400/\$800 Pharmacy deductible	None
Retail Participating Pharmacy (1 Copay for each 30 day supply) <i>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</i>	LEVEL 1: \$20/\$95/\$150/30% to \$250 per script LEVEL 2: \$30/\$105/\$160/40% 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

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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 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 6RK0 and 6RG5 apply to individuals enrolling on their own, with NO dependents. Under these plans, the only the individual deductible applies. Contracts 6RJ5 and 6RH6 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.