



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

California Association of REALTORS® January - December 2024 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) (9KG9) | Bronze PPO 6000/45% HSA (PrevRx) (9KGF) | Silver PPO 2100/30% HSA (PrevRx) (9B29/9B35) (SEE DEDUCTIBLE NOTES) | Silver PPO 2600/35% HSA (PrevRx) (9KGL/9KFG) (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: \$3,200 Family: \$4,200 | Individual (Self-Only) Coverage: \$2,600 Individual within a family: \$3,200 Family: \$5,200 |
| Annual Out of Pocket Maximum (Includes annual deductible) | Individual: \$7,800 Family: \$15,600 | Individual: \$7,400 Family: \$14,800 | Individual: \$7,750 Family: \$15,500 | Individual: \$7,050 Family: \$14,100 |
| ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE EXCEPT PREVENTIVE CARE | | | | |
| Office Visits (Primary Care/Specialist) <i>(virtual and office)</i> | Deductible then 0% coinsurance | Deductible then 45% coinsurance | Deductible then 30% coinsurance | Deductible then 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 \$250 + 45% coinsurance Deductible then 45% coinsurance | Deductible then \$250 + 30% coinsurance Deductible then 30% coinsurance | Deductible then \$250 + 35% coinsurance Deductible then 35% coinsurance |
| Pediatric Dental & Vision Benefits | <i>All Anthem plans include mandatory coverage for pediatric dental and vision benefits. For details of coverage, please refer to the specific plan Summary of Benefits or the Evidence of Coverage document.</i> | | | |
| 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) <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> | 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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| Plans offered by Anthem Blue Cross of California Small Group Prudent Buyer PPO Network | Bronze PPO 70/6600/35% (9B1W) | Bronze PPO 40/6200/40% (9KG2) | Silver PPO 55/2500/45% (9B1X) | Silver PPO 50/2200/40% (9B2Q) | Silver PPO 55/1950/35% (9KGQ) | Silver PPO 45/1750/40% (9KFJ) |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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: \$8,900 Family: \$17,800 | 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) (virtual and office) | 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) |
| 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 Doctor Services | Ded. then \$250 + 35% coinsurance Deductible + 35% coinsurance | Ded. then \$250 + 40% coinsurance Deductible + 40% coinsurance | 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 | 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) Doctor and other services | Deduct. then 35% coinsurance Deduct. then 35% coinsurance | Deduct. then 40% coinsurance Deduct. then 40% coinsurance | 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 | Deduct. then \$250 + 35% coinsurance Deduct. then 35% coinsurance | Deduct. then \$250 + 40% coinsurance Deduct. then 40% coinsurance | Deductible then \$250 + 45% coinsurance Deductible then 45% coinsurance | Deductible then \$250 + 40% coinsurance Deductible then 40% coinsurance | Deductible then \$250 + 35% coinsurance Deductible then 35% coinsurance | Deductible then \$300 + 40% coinsurance Deductible then 40% coinsurance |
| Pediatric Dental & Vision Benefits | <i>All Anthem plans include mandatory coverage for pediatric dental and vision benefits. For details of coverage, please refer to the specific plan Summary of Benefits or the Evidence of Coverage document.</i> | | | | | |
| 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% (9KFU) | Gold PPO 30/750/20% (9KFK) | Gold PPO 30/500/20% (9KF1) | Gold PPO 25/30% (9B25) | Platinum PPO 15/250/10% (9B20) | Platinum PPO 15/40/10% (9B2V) |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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: \$8,500 Family: \$17,000 | Individual: \$3,700 Family: \$7,400 | Individual: \$3,800 Family: \$7,600 |
| ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED | | | | | | |
| Office Visits (Primary Care/Specialist) (virtual and office) | \$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 |
| 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: \$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 \$250 + 20% coinsurance Deductible then 20% coinsurance | Deductible then \$250 + 20% coinsurance Deductible then 20% coinsurance | Deductible then \$250 + 20% coinsurance Deductible then 20% coinsurance | \$250 + 30% coinsurance 30% coinsurance | Deductible then \$250 + 10% coinsurance Deductible then 10% coinsurance | \$200 + 10% coinsurance 10% coinsurance |
| Pediatric Dental & Vision Benefits | <i>All Anthem plans include mandatory coverage for pediatric dental and vision benefits. For details of coverage, please refer to the specific plan Summary of Benefits or the Evidence of Coverage document.</i> | | | | | |
| 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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| Plans offered by Anthem Blue Cross of California CaliforniaCare Network | Silver HMO 55 (9B2Y) | Gold HMO 35 (9B2J) |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Calendar Year Deductible | None | None |
| Annual Out of Pocket Maximum (Includes annual deductible) | Individual: \$9,200 Family: \$18,400 | Individual: \$6,750 Family: \$13,500 |
| Office Visits (Primary Care/Specialist) <i>(virtual and office)</i> | \$55/\$110 Copay | \$35/\$70 Copay |
| 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 |
| Pediatric Dental & Vision Benefits | <i>All Anthem plans include mandatory coverage for pediatric dental and vision benefits. For details of coverage, please refer to the specific plan Summary of Benefits or the Evidence of Coverage document.</i> | |
| Prescription Drug Benefits | | |
| 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:

- * 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.
- * The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- * This health plan includes an Employee Assistance Program (EAP) to support your emotional health and wellness with work life resources including one-on-one counseling by phone, in person and online. Virtual visits are available through LiveHealth Online and Talkspace. 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.

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 9B29 and 9KGL apply to individuals enrolling on their own, with NO dependents. Under these plans, only the individual deductible applies. Contracts 9B35 and 9KFG 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.