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 2025 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	**Bronze PPO 6700/0% HSA (PrevRx) (84VR)**	**Bronze PPO 6000/45% HSA (PrevRx) (84UR)**	**Silver PPO 2100/30% HSA (PrevRx) (84S2(S)/84SD(F))** (SEE DEDUCTIBLE NOTES)	**Silver PPO 2600/35% HSA (PrevRx) (84T7(S)/84T6(F))** (SEE DEDUCTIBLE NOTES)
Small Group Prudent Buyer PPO Network	**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: **$3,300** Family: $4,200	Individual (Self-Only) Coverage: $2,600 Individual within a family: **$3,300** 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) ***(virtual and office)***	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	Deductible then 0% coinsurance	Deductible then 45% coinsurance	Deductible then 30% coinsurance	Deductible then 35% coinsurance
Doctor Services	Deductible then 0% coinsurance	Deductible then 45% coinsurance	Deductible then 30% 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)	Deductible then 0% coinsurance	Deductible then 45% coinsurance	Deductible then 30% coinsurance	Deductible then 35% coinsurance
Doctor and other services	Deductible then 0% coinsurance	Deductible then 45% coinsurance	Deductible then 30% coinsurance	Deductible then 35% coinsurance
Outpatient Surgery				
Facility Fee	Deductible then 0% coinsurance	Deductible then $250 + 45% coinsurance	Deductible then $250 + 30% coinsurance	Deductible then $250 + 35% coinsurance
Doctor Services	Deductible then 0% coinsurance	Deductible then 45% coinsurance	Deductible then 30% coinsurance	Deductible then 35% coinsurance
Pediatric Dental & Vision Benefits	*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.*			
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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Plans offered by Anthem Blue Cross of California ***Small Group Prudent Buyer PPO Network***	**Bronze PPO 70/6600/35% (84QG)**	**Bronze PPO 40/6200/40% (84PV)**	**Silver PPO 55/2500/45% (84P5)**	**Silver PPO 50/2200/40% (84NR)**	**Silver PPO 55/1950/35% (84NG)**	**Silver PPO 45/1750/40% (84MX)**
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, X-Ray (Outpat. Hospital) Imaging (MRI/CT/PET) (Outpat. Hosp.)	Lab Office: Ded then 35% Lab Freestanding: No Charge X-Ray Office or Freestanding: Ded + 35% coinsurance Lab/X-Ray Outpt. Hosp: Ded. + 35% coinsurance MRI/CT/PET: Ded. then $100 + 35% coinsurance	Lab Office: Ded then 40% Lab Freestanding: No Charge X-Ray Office or 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. +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 $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	Deduct. then $250 + 45% coinsurance Deductible then 45% coinsurance	Deduct. then $250 + 40% coinsurance Deduct. then 40% coinsurance	Deduct. then $250 + 35% coinsurance Deduct. then 35% coinsurance	Deduct. then $300 + 40% coinsurance Deduct. then 40% coinsurance
Pediatric Dental & Vision Benefits	*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.*					
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% (807B)**	**Gold PPO 30/750/20% (806Z)**	**Gold PPO 30/500/20% (805T)**	**Gold PPO 25/30% (8058)**	**Platinum PPO 15/250/10% (8047)**	**Platinum PPO 15/40/10% (803Z)**
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: $8,700 Family: $17,400	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/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	Deduct. then $250 + 20% coinsurance	Deduct. then $250 + 20% coinsurance	Deduct. then $250 + 20% coinsurance	$250 + 30% coinsurance	Deduct. then $250 + 10% coinsurance	$200 + 10% coinsurance
Doctor Services	Deduct. then 20% coinsurance	Deduct. then 20% coinsurance	Deduct. then 20% coinsurance	30% coinsurance	Deduct. then 10% coinsurance	10% coinsurance
Pediatric Dental & Vision Benefits	*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.*					
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) *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/$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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Plans offered by Anthem Blue Cross of California CaliforniaCare Network	**Silver HMO 55 (8027)**	**Gold HMO 35 (7ZZG)**
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) ***(virtual and office)***	$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: $40 Copay Lab Freestanding: No charge Lab Outpt. Hosp: $55 Copay X-Ray Office: $40 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	*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.*	
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) *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/$95/$150/30% to $250 per script LEVEL 2: **$25**/$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 84S2(S) and 84T7(S) apply to individuals enrolling on their own, with NO dependents. Under these plans, only the individual deductible applies. Contracts 84SD(F) and 84T6(F) 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.