



**California Association of REALTORS®
2009 Anthem Blue Cross of California
Medical Plans Benefit Summary (1)**

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

Benefits shown are for Preferred Providers ONLY. Benefits shown are always based on the Blue Cross negotiated fee. Benefits for Non Preferred Providers are significantly reduced.

Benefit Description	Premier PPO \$20 Copay	PPO \$30 Copay	PPO \$35 Copay GenRx	Saver HMO
Calendar Year Deductible	\$250/member	\$500/member	\$500/member	\$1500/member (applies to inpatient & outpatient facility services, ambulatory surgical centers & dialysis centers. (Does not apply to emergencies))
Lifetime Maximum Benefit	\$5 million	\$5 million	\$5 million	Unlimited
Annual Out of Pocket Maximum	\$3000/member, two member maximum/year	\$4000/member, two member maximum/year	\$4000/member, two member maximum/year	\$2250/member, \$4500/family aggregate
ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED				
Office Visits (Not subject to annual deductible for the PPO 20, PPO 30, PPO 35)	\$20 copay for initial 12 visits, then 40% of negotiated fee (2)	\$30 Copay for initial 12 visits, then 45% of the negotiated fee (2)	\$35 Copay for initial 12 visits, then 45% of the negotiated fee (2)	\$20/visit (2)
Other Professional Services including diagnostic lab & X ray	20% of negotiated fee	30% of negotiated fee	35% of negotiated fee	No Charge
Hospital Inpatient Facility Services Preservice Review required	20% of negotiated fee	30% of negotiated fee	35% of negotiated fee	No charge after deductible
Hospital Inpatient Professional Services (lab,physician, anesthesia)	20% of negotiated fee	30% of negotiated fee	35% of negotiated fee	No Charge
Outpatient Facility Services Preservice Review required for certain surgical services and diagnostic procedures	20% of negotiated fee	30% of negotiated fee	35% of negotiated fee	No charge after deductible
Prescription Drugs	None	\$150/member for brand name & brand name self injectables	None	\$150/member per calendar year for brand name drugs & home administered injectables.
Rx Deductible				
Prescription Benefits	Generic: \$15/Rx Brand Formulary: \$25/Rx	Generic: \$15/Rx Brand Formulary: \$25/Rx	Generic: \$15/Rx Brand: Not covered	Generic: \$10/Rx Brand Formulary: \$25/Rx
Self Injectables	30% of negotiated fee up to \$100 copay max/Rx	30% of negotiated fee up to \$100 copay max/Rx	30% of negotiated fee up to \$100 copay max/Rx	30% of negotiated fee up to \$100 copay max/Rx
ANNUAL PREVENTIVE CARE				
Physical Exam (Not subject to deductible, if applicable) Limited Benefits Apply	\$25 or \$75 Copay for Healthy Check Screening OR \$20 Copay for office visit plus 20% of negotiated fee up to max \$100 (or \$200 if covered 6mos.)	\$25 or \$75 Copay for Healthy Check Screening \$30 Copay + 30% of negotiated fee for annual Pap, breast exam, mammogram and PSA testing	\$25 or \$75 Copay for Healthy Check Screening \$35 Copay + 35% of negotiated fee for annual Pap, breast exam, mammogram and PSA testing	\$20 Copay
Emergency Care	\$100 Copay + 20% of negotiated fee after deductible	\$100 copay + 30% of negotiated fee after deductible	\$100 copay + 35% of negotiated fee after deductible	\$100/visit, waived if admitted
Ambulance	20% of negotiated fee	30% of negotiated fee	35% of negotiated fee	No Charge in a medical emergency or if ordered by PCP
Skilled Nursing Facility (up to 100 days/calendar year)	20% of negotiated fee	30% of negotiated fee	35% of negotiated fee	No Charge, up to 100 days/year
Home Health Care (up to 100 days/calendar year)	20% of negotiated fee	30% of negotiated fee	35% of negotiated fee	No Charge if ordered by PCP; up to 3 two hour visits/day
Physical/Occupational Therapy/Chiropractic Care	20% of negotiated fee	30% of negotiated fee	35% of negotiated fee	20% of negotiated fee
	Up to 12 visits/calendar year			
Mental Health Outpatient Professional Services (Non Severe) (up to 20 visits per calendar year)	100% of charges in excess of \$25 per visit	100% of charges in excess of \$25 per visit	100% of charges in excess of \$25 per visit	\$20/visit

(1) This document is a summary of benefits only. Refer to contract for a detailed explanation of plan benefits, features, exclusions and limitations. Benefits valid for plan year 6/1/09 to 5/31/10 and subject to change without notice. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: www.Realcare.biz/eoc

(2) Not subject to plan deductible

The Small Group Saver HMO, Premier \$20 Copay and PPO \$30 Copay plans are offered by Anthem Blue Cross. The Small Group PPO35 GenRx, PPO 2400 (HSA Compatible) and Lumenos \$3500 80/50 plans are offered by Anthem Blue Cross Life & Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensees of the Blue Cross Association.

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	HSA Compatible - High Deductible Health Plans	
Benefit Description	PPO 2400 High Deductible	Lumenos 3500 80/50
	PPO 2400 TO BE DISCONTINUED 6/1/10	
Calendar Year Deductible	\$2400 per person, \$4800 per family <i>aggregate</i>	\$3500 per person, \$7000 per family <i>aggregate</i>
Lifetime Maximum Benefit	\$5 million	\$5 million
Annual Out of Pocket Maximum	\$3600/member; \$5500/family <i>aggregate</i>	\$5000/member; \$10000/family <i>aggregate</i>
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED	
Office Visits	\$35 Copay	20% of negotiated fee
Other Professional Services including diagnostic lab & X ray	20% of negotiated fee	20% of negotiated fee
Hospital Inpatient Facility Services <small>Preservice Review required</small>	20% of negotiated fee	20% of negotiated fee
Hospital Inpatient Professional Services (lab, physician, anesthesia)	20% of negotiated fee	20% of negotiated fee
Outpatient Facility Services <small>Preservice Review required for certain surgical services and diagnostic procedures</small>	20% of negotiated fee	20% of negotiated fee
Prescription Drugs	Subject to <i>Medical</i> Plan Deductible	Subject to <i>Medical</i> Plan Deductible
Rx Deductible		
Prescription Benefits	Generic: \$10/Rx after deductible Brand: \$25/Rx after deductible	Generic: \$10/Rx after deductible Brand: \$30/Rx after deductible Non-Formulary Brand: \$50/Rx after deductible
Self Injectables	30%/Rx	30%/Rx
ANNUAL PREVENTIVE CARE		
Physical Exam (Not subject to deductible, if applicable) Limited Benefits Apply	\$25 or \$75 Copay for Health Check Screening OR \$35 + 20% of negotiated fee for annual physical exam and related covered services up to \$100 (or \$200 if covered 6 mos.)	No Charge for nationally recommended preventive services - no deductible applies
Emergency Care	\$100 Copay + 20% of negotiated fee after deductible	20% of negotiated fee
Ambulance	20% of negotiated fee	20% of negotiated fee
Skilled Nursing Facility (up to 100 days/calendar year)	20% of negotiated fee	20% of negotiated fee
Home Health Care (up to 100 days/calendar year)	20% of negotiated fee	20% of negotiated fee
Physical/Occupational Therapy/Chiropractic Care	20% of negotiated fee	20% of negotiated fee
	Up to 12 visits/calendar year	Up to 24 visits per calendar year
Mental Health Outpatient Professional Services (Non Severe) (up to 20 visits per calendar year)	100% of charges in excess of \$25 per visit	100% of charges in excess of \$25 per visit

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