Anthem

RealCare INSURANCE

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

California Association of REALTORS®
2010 Anthem Blue Cross of California
Medical Plans Benefit Summary (1)

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 * Offered by Anthem Blue Cross ** Offered by Anthem Blue Cross Life and Health Insurance Company	**Premier PPO $20 Copay***	**PPO $30 Copay***	**PPO $35 Copay GenRx****	**Lumenos HSA 3500 (80/50)****	**Saver $20 HMO***
Calendar Year Deductible	$250 per member Two member maximum	$500/member Two Member Maximum	$500/member Two Member Maximum	$3500 per person $7000 per family aggregate; medical/pharmacy combined (7,8)	$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	$5 million	Unlimited
Annual Out of Pocket Maximum (2) (Includes annual deductible)	$3000 per member Two member maximum	$4000/member Two member maximum	$4000/member Two member maximum	$5000/member; $10000/family aggregate; medical/pharmacy combined (7,8)	$2250/member, $4500/family aggregate(8)
	ALL BENEFITS LISTED ARE AFTER ANNUAL DEDUCTIBLE UNLESS OTHERWISE NOTED				
Office Visits	$20 copay (3)	$30 Copay (3)	$35 Copay (3)	20% after deductible	$20 copay (3)
Professional Services (Including maternity, diagnostic lab & X- rays)	20% of negotiated fee	30% of negotiated fee	35% of negotiated fee	20% of negotiated fee	No Charge (except $100 copay for complex radiology services obtained in a non-hospital based facility and office visit copay for maternity services)
Emergency Care ($100 Emergency Room copayment for each visit - waived if admitted)	20% of negotiated fee	30% of negotiated fee	35% of negotiated fee	20% of negotiated fee	No charge
Hospital Inpatient Facility Services (Preservice Review required)	20% of negotiated fee	30% of negotiated fee	35% of negotiated fee	20% 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	20% 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	20% of negotiated fee	No charge after deductible
Prescription Drugs Rx Deductible	None	$150 annual brand-name prescription drug deductible per member applies to all covered brand-name drugs	None **Brand: Not covered**	After combined medical/pharmacy deductible	$150 annual brand-name prescription drug deductible per member applies to all covered brand-name drugs
Prescription Benefits (Amounts shown are copays for each 30-day supply)	Generic: $10/Rx Formulary Brand: $25/Rx (4) Nonformulary Brand: $40/Rx (4)	Generic: $10/Rx Formulary Brand: $30/Rx (5) Nonformulary Brand: $45/Rx (5)	Generic: $10/Rx ***Brand: Not covered***	Generic: $10/Rx after deductible Formulary Brand: $30/Rx after deductible (5) Nonformulary Brand: $50/Rx after deductible (5)	Generic: $10/Rx Formulary Brand: $25/Rx (5) Nonformulary brand: $40/Rx (5)
Self Injectables	30% of negotiated fee up to $100 per fill (except insulin)	30% of negotiated fee up to $100 copay max/Rx (except insulin)	Generic Self Injectables: 30% of negotiated fee up to a maximum $100 member copay per fill (except insulin)	Self Injectables: 30% of negotiated fee (except insulin)	30% of negotiated fee up to a maximimum $100 member copay per fill (except insulin)
PREVENTIVE CARE (Well Baby/Well Child through age 6, and adult screenings)	$20 office visit copay (3) **plus** 20% of negotiated fee for all other covered services beyond that related office visit (after deductible)	$30 office visit copay (3) **plus** 30% of negotiated fee for all other covered services beyond that related office visit (after deductible)	$35 office visit copay (3) **plus** 35% of negotiated fee for all other covered services beyond that related office visit (after deductible)	0% of negotiated fee includes nationally recommended preventive care service (not subject to deductible)	$20 copay (3)
Physical Exam (Not subject to deductible)	$25 or $75 copay for Healthy Check Screening **OR** $20 copay for office visit **plus** 20% of negotiated fee for all other services beyond that related office visit (6)	$25 or $75 copay for Healthy Check Screening **OR** $30 copay **plus** 30% of negotiated fee for all other covered services beyond that related office visit (6)	$25 or $75 copay for Healthy Check Screening **OR** $35 copay **plus** 35% of negotiated fee for all other covered services beyond that related office visit (6)	0% of negotiated fee covered under preventive care (not subject to deductible)	Covered under Preventive Care
Ambulance	20% of negotiated fee	30% of negotiated fee	35% of negotiated fee	20% of negotiated fee	No Charge in a medical emergency or if ordered by PCP

(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 6/1/10 to 5/31/11 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) Annual out-of-pocket maximum: Expenses that contribute to the maximum payment limit vary from plan to plan and have restrictions and limitations. Refer to each plan's ***Combined Evidence of Coverage and Disclosure Form*** or ***Certificate*** for full details.

(3) Not subject to plan deductible.

(4) Members may select a brand-name drug when a generic drug is available if the physician writes, "dispense as written" or "do not substitute" prescription.

(5) If a member selects a brand-name drug when a generic-equivalent drug is available, even if the physician writes a "dispense as written" or "do not substitute" prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug. The amount paid does not apply to the member's brand-name deductible (except Lumenos HSA).

(6) Annual physical exam: Maximum annual Anthem Blue Cross payment of $500 for members covered more than six months; $250 for members covered six months or less, in network and out of network combined. Refer to each plan's ***Combined Evidence of Coverage and Disclosure Form*** or ***Certificate*** for full details.

(7) Lumenos HSA 3500 (80/50) plan annual deductible and annual out-of-pocket maximum: medical/pharmacy combined; in-network and out-of-network combined; certain payments do not apply.

(8) Per family amount is aggregate, i.e., if one or more family member's eligilbe covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members.

Note: A high-deductible health plan is not an HSA. An HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Consultation with a tax advisor is recommended.