

Feature	Anthem Ingalls Represented Medical Plan	
	In-Network	Out-of-Network
Provider	Anthem Blue Cross 1-800-948-3648 www.anthem.com/ca	
Cost Sharing		
Annual Deductible	\$300 Individual; \$600 Family	\$800 Individual; \$1,600 Family
Out-of-pocket maximum	\$2,000 Individual; \$4,000 Family	\$5,000 Individual; \$10,000 Family
Lifetime coverage limit	\$1,000,000; in and out-of-network combined; retiree and active combined	
Policies/Requirements		
Need to file claims	No	Yes; check with Plan for details
Domestic partner benefits	No	No
Access		
Ability to self-refer to OB/GYN	Yes	Yes
Ability to self-refer to specialists	Yes	Yes
Out-of-area dependent coverage	Yes	Yes
Out-of-area participant coverage	Yes	Yes
Spending Account		
You only	Not applicable	Not applicable
You and spouse	Not applicable	Not applicable
You and child	Not applicable	Not applicable
You and family	Not applicable	Not applicable
Eligible expenses for reimbursement	Not applicable	Not applicable
Outpatient Services		
Primary doctor office visit	\$15 copay	60% covered after deductible is met
Specialist doctor office visit	\$30 copay	60% covered after deductible is met
Preventive Care		
Annual physical exam	\$15 copay; PCP; \$30 copay specialist; limited to \$200 per benefit plan year for all preventive care combined; wellness limited to age 7 and over	100% covered; limited to \$200 per benefit plan year for all preventive care combined; wellness limited to age 7 and over
Well-woman exam (includes pap)	\$15 copay; PCP; limited to \$200 per benefit plan year for all preventive care combined; limited to one routine exam per benefit plan year	100% covered; limited to \$200 per benefit plan year for all preventive care combined; limited to one routine exam per benefit plan year
Mammogram	100% covered; limited to \$200 per benefit plan year for all preventive care combined	100% covered; limited to \$200 per benefit plan year for all preventive care combined
Pediatric exams	\$15 copay; limited to \$200 per benefit plan year for all preventive care combined	Not covered
Immunizations (child)	100% covered; limited to \$200 per benefit plan year for all preventive care combined	Not covered
Colonoscopy	100% covered; limited to \$200 per benefit plan year for all preventive care combined	100% covered; limited to \$200 per benefit plan year for all preventive care combined

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Cancer screenings	100% covered; limited to \$200 per benefit plan year for all preventive care combined	100% covered; limited to \$200 per benefit plan year for all preventive care combined
Cardiovascular screenings	100% covered; limited to \$200 per benefit plan year for all preventive care combined	100% covered; limited to \$200 per benefit plan year for all preventive care combined
Allergy tests and treatments	Not covered	Not covered
Outpatient Care		
Outpatient surgery	90% covered after deductible is met; deductible waived for ambulatory surgical center	60% covered after deductible is met
Outpatient laboratory services	90% covered after deductible is met	60% covered after deductible is met
Outpatient physical therapy	90% covered after deductible is met	60% covered after deductible is met
Outpatient X-ray	90% covered after deductible is met	60% covered after deductible is met
Outpatient occupational therapy	Not covered	Not covered
Outpatient speech therapy	Not covered	Not covered
Outpatient cardiac rehabilitation	90% covered after deductible is met	60% covered after deductible is met
Family Planning / Maternity Care		
Office visit: pre/postnatal	\$15 copay	60% covered after deductible is met
In-hospital delivery services	90% covered; preauthorization required	60% covered after deductible is met; preauthorization required
Newborn nursery services	100% covered	Not covered
Fertility services	Not covered	Not covered
In vitro fertilization	Not covered	Not covered
Artificial insemination	Not covered	Not covered
Female tubal ligation	90% covered after deductible is met	60% covered after deductible is met
Male vasectomy	90% covered after deductible is met	60% covered after deductible is met
Hearing		
Hearing evaluations	Not covered	Not covered
Hearing aids	Not covered	Not covered
Vision		
Routine vision exams	Not covered	Not covered
Regular lenses and frames	Not covered	Not covered
Contact lenses	Not covered	Not covered
Dental		
Dental implants	Not covered	Not covered
Accidental injury to teeth	90% covered after deductible is met	60% covered after deductible is met
Surgical removal of tumors, cysts and impacted teeth	90% covered after deductible is met	60% covered after deductible is met
Inpatient Services		
Hospital copay	90% covered; precertification required; \$300 penalty for failure to call	60% covered; after deductible is met; precertification required; \$300 penalty for failure to call
Hospital semi-private room	90% covered	60% covered; after deductible is met
Inpatient lab and X-ray	90% covered	60% covered; after deductible is met
Inpatient surgery	90% covered	60% covered after deductible is met
Inpatient physician and surgeon services	90% covered; after deductible is met; preauthorization required	60% covered; after deductible is met; preauthorization required

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Emergency Care		
Emergency room (not followed by admission)	90% covered after deductible is met; check with Plan for details about limitations	80% covered after deductible is met; check with Plan for details about limitations
Urgent care clinic visit	90% covered after deductible is met	60% covered after deductible is met
Ambulance services	90% covered; in and out-of network; non-emergencies not covered	
Prescription Drug Coverage		
Annual prescription deductible	\$0 Individual; \$0 Family	\$0 Individual; \$0 Family
Prescription drug website	www.express-scripts.com	
Prescription drug member services	1-800-655-1971	
Prescription drug vendor	Express Scripts	
Annual Rx out-of-pocket maximum	Not applicable	
Retail		
Retail generic	\$5 copay; 90 day supply	\$5 copay; 90 day supply; member must submit claim for reimbursement of allowable expenses less the \$5 copay
Retail formulary brand	\$20 copay; 90 day supply	\$20 copay; 90 day supply; member must submit claim for reimbursement of allowable expenses less the \$20 copay
Retail nonformulary brand	\$30 copay; 90 day supply	\$30 copay; 90 day supply; member must submit claim for reimbursement of allowable expenses less the \$30 copay
Mail Order		
Mail order generic	\$5 copay; 90 day supply	Not covered
Mail order formulary brand	\$20 copay; 90 day supply	Not covered
Mail order nonformulary brand	\$30 copay; 90 day supply	Not covered
Other		
Oral contraceptives	Retail and mail order available; must be medically necessary	Retail available only; must be medically necessary
Fertility drugs	Not covered	Not covered
Injectables	Applicable medical or prescription drug coinsurance or copays apply; check with Anthem or Express Scripts for details	
Mental Health		
Mental Health: Combined with substance abuse	No	No
Mental Health: Outpatient coverage	Not covered	Not covered
Mental Health: Inpatient coverage	90% covered; limited to 30 days per benefit plan year; in- and out-of-network combined	60% covered; limited to 30 days per benefit plan year; in- and out-of-network combined

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Substance Abuse		
Detox: Outpatient coverage	Not covered	Not covered
Detox: Inpatient coverage	90% covered; limited to \$1,000 for alcohol and \$1,000 for any other drug rehab per benefit plan year; in & out-of-network combined	60% covered; limited to \$1,000 for alcohol and \$1,000 for any other drug rehab per benefit plan year; in & out-of-network combined
Rehab: Outpatient coverage	Not covered	Not covered
Rehab: Inpatient coverage	90% covered; limited to \$1,000 for alcohol and \$1,000 for any other drug rehab per benefit plan year; in- & out-of-network combined	60% covered; limited to \$1,000 for alcohol and \$1,000 for any other drug rehab per benefit plan year; in- & out-of-network combined
Alternative Care		
Chiropractic	100% covered; limited to \$40 for initial visit & \$10 per visit thereafter; limited to 37 visits per benefit plan year; in and out-of-network combined	100% covered; limited to \$40 for initial visit & \$10 per visit thereafter; limited to 37 visits per benefit plan year; in and out-of-network combined
Acupuncture	Not covered	Not covered
Care Management Programs		
Heart disease care management	No	
Hypertension care management	No	
Diabetes care management	No	
Asthma care management	No	
Prenatal care management	No	
Cancer care management	No	
Smoking cessation program	No	
Weight control program	No	
Other		
Noncustodial home health care	90% covered; if precertified by case management that it is more cost effective to be in HHC; otherwise, not covered	60% covered; if precertified by case management that it is more cost effective to be in HHC; otherwise, not covered
Hospice care	90% covered after deductible is met	60% covered after deductible is met
Prescribed care in noncustodial skilled nursing facility	90% covered; if precertified by case management that it is more cost effective to be in SNF; otherwise, not covered	60% covered; if precertified by case management that it is more cost effective to be in SNF; otherwise, not covered
Durable medical equipment	90% covered after deductible is met	60% covered after deductible is met
Prosthetic devices	90% covered after deductible is met	60% covered after deductible is met