

Feature	Anthem NGHP Preferred PPO	
	In-Network	Out-of-Network
Provider	Anthem Blue Cross 1-866-504-9638 www.anthem.com/ca	
Cost Sharing		
Annual Deductible	\$500 Individual; \$1,000 Family	\$800 Individual; \$1,600 Family
Out-of-pocket maximum	\$3,000 Individual; \$6,000 Family	\$5,000 Individual; \$10,000 Family
Lifetime coverage limit	\$2,000,000; for all Northrop Grumman-sponsored medical plan options; retiree and active combined; in and out-of-network combined	
Policies/Requirements		
Need to file claims	No	Yes
Domestic partner benefits	Yes	Yes
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	\$20 copay	60% covered after deductible is met
Specialist doctor office visit	\$40 copay	60% covered after deductible is met
Preventive Care		
Annual physical exam	\$20 copay; PCP; \$40 copay specialist; services must meet prescribed definition of preventive services	Not covered
Well-woman exam (includes pap)	\$20 copay; PCP; \$40 copay specialist; services must meet prescribed definition of preventive services	Not covered
Mammogram	100% covered; services must meet prescribed definition of preventive services	Not covered
Pediatric exams	\$20 copay; PCP; \$40 copay specialist; services must meet prescribed definition of preventive services	Not covered
Immunizations (child)	100% covered; coverage based on American Academy of Pediatrics guidelines; services must meet prescribed definition of preventive services	Not covered

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Colonoscopy	100% covered; services must meet prescribed definition of preventive services	Not covered
Cancer screenings	100% covered; services must meet prescribed definition of preventive services	Not covered
Cardiovascular screenings	100% covered; services must meet prescribed definition of preventive services	Not covered
Allergy tests and treatments	90% covered after deductible is met	60% covered after deductible is met
Outpatient Care		
Outpatient surgery	90% covered after deductible is met	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; limited to 50 visits per benefit plan year; in- and out-of-network combined	60% covered after deductible; limited to 50 visits per benefit plan year; in- and out-of-network combined
Outpatient X-ray	90% covered after deductible is met	60% covered after deductible is met
Outpatient occupational therapy	90% covered after deductible is met; limited to 50 visits per benefit plan year; in and out-of-network combined	60% covered after deductible is met; limited to 50 visits per benefit plan year; in and out-of-network combined
Outpatient speech therapy	90% covered after deductible is met; limited to 50 visits per benefit plan year; in and out-of-network combined	60% covered after deductible is met; limited to 50 visits per benefit plan year; in and out-of-network combined
Outpatient cardiac rehabilitation	90% covered after deductible is met; limited to Phase 1 and Phase 2 care	60% covered after deductible is met; limited to Phase 1 and Phase 2 care
Family Planning / Maternity Care		
Office visit: pre/postnatal	\$20 copay	60% covered after deductible is met
In-hospital delivery services	90% covered after deductible is met	60% covered after deductible is met
Newborn nursery services	90% covered after deductible is met	60% covered after deductible is met
Fertility services	90% covered after deductible is met; limited to \$12,500 per lifetime; in and out-of-network combined; includes Rx	60% covered after deductible is met; limited to \$12,500 per lifetime; in and out-of-network combined; includes Rx
In vitro fertilization	90% covered after deductible is met; limited to \$12,500 per lifetime for all fertility services combined, including Rx; in and out-of-network combined	60% covered after deductible is met; limited to \$12,500 per lifetime for all fertility services combined, including Rx; in and out-of-network combined
Artificial insemination	90% covered after deductible is met; limited to \$12,500 per lifetime for all fertility services combined, including Rx; in and out-of-network combined	60% covered after deductible is met; limited to \$12,500 per lifetime for all fertility services combined, including Rx; in and out-of-network combined
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	90% covered; limited to one exam and \$1,000 per benefit plan year for all hearing services	60% covered; limited to one exam and \$1,000 per benefit plan year for all hearing services

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Hearing aids	90% covered; limited to \$1,000 per benefit plan year for all hearing services	60% covered after deductible is met; limited to \$1,000 per benefit plan year for all hearing services
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; after deductible is met; preauthorization required	60% covered; after deductible is met; preauthorization required
Hospital semi-private room	90% covered after plan deductible; preauthorization required	60% covered; after deductible is met; preauthorization required
Inpatient lab and X-ray	90% covered; after deductible is met	60% covered; after deductible is met
Inpatient surgery	90% covered after deductible; preauthorization required	60% covered; after deductible is met
Inpatient physician and surgeon services	90% covered; after deductible is met	60% covered; after deductible is met
Emergency Care		
Emergency room (not followed by admission)	90% covered after deductible is met	90% covered after deductible is met; true emergency; 60% covered after deductible is met for non-emergencies
Urgent care clinic visit	90% covered after deductible is met	60% covered after deductible is met
Ambulance services	90% covered after deductible is met; in and out-of network; non-emergencies not covered	
Prescription Drug Coverage		
Annual prescription deductible	\$0 Individual; \$0 Family	\$50 Individual; \$100 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	\$2,000 Individual; \$4,000 Family; in and out-of-network combined	
Retail		
Retail generic	\$5 copay or 10% coinsurance whichever is greater; 30 day supply	50% covered; 30 day supply
Retail formulary brand	\$20 copay or 10% coinsurance whichever is greater; 30 day supply; chemically equivalent generics required; check with Plan for details	50% covered; 30 day supply; chemically equivalent generics required; check with Plan for details
Retail nonformulary brand	\$40 copay or 10% coinsurance whichever is greater; 30 day supply; chemically equivalent generics required; check with Plan for details	50% covered; 30 day supply; chemically equivalent generics required; check with Plan for details

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	Mail Order	
Mail order generic	\$5 copay or 10% coinsurance whichever is greater; 90 day supply; mail order required for maintenance medications; check with Plan for details	Not covered
Mail order formulary brand	\$20 copay or 10% coinsurance whichever is greater; 90 day supply; chemically equivalent generics required; mail order required for maintenance medications; check with Plan for details	Not covered
Mail order nonformulary brand	\$40 copay or 10% coinsurance whichever is greater; 90 day supply; chemically equivalent generics required; mail order required for maintenance medications; check with Plan for details	Not covered
	Other	
Oral contraceptives	Retail and mail order available	Not covered
Fertility drugs	Covered under Medical	Covered under Medical
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	Yes	Yes
Mental Health: Outpatient coverage	\$15 copay	60% covered; limited to 30 visits per benefit plan year
Mental Health: Inpatient coverage	90% covered	60% covered; limited to 30 days per benefit plan year
	Substance Abuse	
Detox: Outpatient coverage	90% covered; limited to 3 courses of treatment per lifetime; in and out-of-network combined	60% covered; limited to 30 days per benefit plan year; limited to 3 courses of treatment per lifetime; in and out-of-network combined
Detox: Inpatient coverage	90% covered; limited to 3 courses of treatment per lifetime; in and out-of-network combined	60% covered; limited to 30 days per benefit plan year; limited to 3 courses of treatment per lifetime; in and out-of-network combined
Rehab: Outpatient coverage	\$15 copay	60% covered; limited to 30 visits per benefit plan year
Rehab: Inpatient coverage	90% covered; limited to 3 courses of treatment per lifetime; in and out-of-network combined	60% covered; limited to 30 days per benefit plan year; limited to 3 courses of treatment per lifetime; in and out-of-network combined

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	Alternative Care	
Chiropractic	\$40 copay; 90% covered after deductible is met if no office visit billed; limited to 40 visits per benefit plan year; in and out-of-network combined	60% covered after deductible is met; limited to 40 visits per benefit plan year; in and out-of-network combined
Acupuncture	90% covered after deductible is met; limited to 20 visits per benefit plan year; in and out-of-network combined	60% covered after deductible is met; limited to 20 visits per benefit plan year; in and out-of-network combined
	Care Management Programs	
Heart disease care management	Yes	
Hypertension care management	Yes	
Diabetes care management	Yes	
Asthma care management	Yes	
Prenatal care management	Yes	
Cancer care management	Yes	
Smoking cessation program	No	
Weight control program	No	
	Other	
Noncustodial home health care	90% covered after deductible is met; limited to 120 visits per benefit plan year; in and out-of-network combined; preauthorization required	60% covered after deductible is met; limited to 120 visits per benefit plan year; in and out-of-network combined; preauthorization required
Hospice care	90% covered after deductible is met	60% covered after deductible is met
Prescribed care in noncustodial skilled nursing facility	90% covered after deductible is met; limited to 120 days per benefit plan year; in and out-of-network combined; preauthorization required	60% covered after deductible is met; limited to 120 days per benefit plan year; in and out-of-network combined; preauthorization required
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