

Plan Facts

Anthem Preferred PPO	
Web site	anthem.com/ca
Member services	1-866-504-9638; ongoing; 1-866-641-1686 for pre-enrollment
Find a network provider	Find a Doctor or Hospital
Binding arbitration	No

Cost

Anthem Preferred PPO	
Health Reimbursement Arrangement	
Eligible expenses for reimbursement	Not applicable
General Medical Expenses	
Deductible: Individual/Family	In Network \$500 Individual; \$1,000 Family Out of Network \$800 Individual; \$1,600 Family
Primary doctor office visit	In Network \$20 copay Out of Network 60% covered after deductible is met
Specialist office visit	In Network \$40 copay Out of Network 60% covered after deductible is met
Out-of-pocket maximum: Individual/Family	In Network \$3,000 Individual; \$6,000 Family Out of Network \$5,000 Individual; \$10,000 Family
Lifetime coverage limit	In Network \$2,000,000; for all Northrop Grumman-sponsored medical plan options; retiree and active combined; in and out-of-network combined Out of Network \$2,000,000; for all Northrop Grumman-sponsored medical plan options; retiree and active combined; in and out-of-network combined
Inpatient Hospital Care	
Hospital copay	In Network 90% covered; after deductible is met; preauthorization required Out of Network 60% covered; after deductible is met; preauthorization required
Hospital semi-private room	In Network 90% covered; after deductible is met; preauthorization required Out of Network

	60% covered; after deductible is met; preauthorization required
Inpatient lab and X-ray	In Network 90% covered; after deductible is met Out of Network 60% covered; after deductible is met
Inpatient physician and surgeon services	In Network 90% covered; after deductible is met Out of Network 60% covered; after deductible is met
Outpatient Care	
Outpatient surgery	In Network 90% covered after deductible is met Out of Network 60% covered after deductible is met
Outpatient laboratory services	In Network 90% covered after deductible is met Out of Network 60% covered after deductible is met
Outpatient X-ray	In Network 90% covered after deductible is met Out of Network 60% covered after deductible is met
Emergency room (not followed by admission)	In Network 90% covered after deductible is met Out of Network 90% covered after deductible is met; true emergency; 60% covered after deductible is met for non-emergencies
Urgent care clinic visit	In Network 90% covered after deductible is met Out of Network 60% covered after deductible is met
Prescription Drug Expenses	
Prescription drug vendor	Not applicable
Prescription drug Web site	Not applicable
Prescription drug member services	Not applicable
Annual prescription deductible	In Network Not applicable Out of Network Not applicable
Retail generic	In Network Not applicable Out of Network Not applicable
Retail formulary brand	In Network Not applicable Out of Network Not applicable
Retail nonformulary brand	In Network Not applicable

	Out of Network Not applicable
Mail order generic	Not applicable
Mail order formulary brand	Not applicable
Mail order nonformulary brand	Not applicable
Oral contraceptives	In Network Not applicable
	Out of Network Not applicable

Coverage

Anthem Preferred PPO

Adult Preventive Care

Physical exam	In Network \$20 copay; PCP; \$40 copay specialist; services must meet prescribed definition of preventive services Out of Network Not covered
Well-woman exam (includes pap)	In Network \$20 copay; PCP; \$40 copay specialist; services must meet prescribed definition of preventive services Out of Network Not covered
Mammogram	In Network 100% covered; services must meet prescribed definition of preventive services Out of Network Not covered
Cancer screenings	In Network 100% covered; services must meet prescribed definition of preventive services Out of Network Not covered
Cardiovascular screenings	In Network 100% covered; services must meet prescribed definition of preventive services Out of Network Not covered

Family Planning

Fertility drugs	In Network Not applicable Out of Network Not applicable
Fertility services	In Network

	90% covered after deductible is met; limited to \$12,500 per lifetime; in and out-of-network combined; includes Rx
	Out of Network 60% covered after deductible is met; limited to \$12,500 per lifetime; in and out-of-network combined; includes Rx
Artificial insemination	In Network 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 Out of Network 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
In vitro fertilization	In Network 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 Out of Network 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
Male vasectomy	In Network 90% covered after deductible is met Out of Network 60% covered after deductible is met
Maternity Care	
Office visit: Pre/postnatal	In Network \$20 copay Out of Network 60% covered after deductible is met
In-hospital delivery services	In Network 90% covered after deductible is met Out of Network 60% covered after deductible is met
Newborn nursery services	In Network 90% covered after deductible is met Out of Network 60% covered after deductible is met
Prenatal care management	No
Well-Baby/Well-Child Preventive Care	
Well-child exams	In Network \$20 copay; PCP; \$40 copay specialist; services must meet prescribed definition of preventive services Out of Network Not covered

Immunizations (child)	<p>In Network 100% covered; coverage based on American Academy of Pediatrics guidelines; services must meet prescribed definition of preventive services</p> <p>Out of Network Not covered</p>
Mental Health Care	
Mental Health: Combined with substance abuse	<p>In Network Yes</p> <p>Out of Network Yes</p>
Mental Health: Outpatient coverage	<p>In Network \$15 copay</p> <p>Out of Network 60% covered; limited to 30 visits per benefit plan year</p>
Mental Health: Inpatient coverage	<p>In Network 90% covered</p> <p>Out of Network 60% covered; limited to 30 days per benefit plan year</p>
Substance Abuse Care	
Detox: Outpatient coverage	<p>In Network 90% covered; limited to 3 courses of treatment per lifetime; in and out-of-network combined</p> <p>Out of Network 60% covered; limited to 30 days per benefit plan year, rehab & detox combined; limited to 3 courses of treatment per lifetime; in & out-of-network combined</p>
Detox: Inpatient coverage	<p>In Network 90% covered; limited to 3 courses of treatment per lifetime; in and out-of-network combined</p> <p>Out of Network 60% covered; limited to 30 days per benefit plan year, rehab & detox combined; limited to 3 courses of treatment per lifetime; in & out-of-network combined</p>
Rehab: Outpatient coverage	<p>In Network \$15 copay</p> <p>Out of Network 60% covered; limited to 30 visits per benefit plan year</p>
Rehab: Inpatient coverage	<p>In Network</p>

90% covered; limited to 3 courses of treatment per lifetime; in and out-of-network combined

Out of Network

60% covered; limited to 30 days per benefit plan year, rehab & detox combined; limited to 3 courses of treatment per lifetime; in & out-of-network combined

Dental Care

Dental implants

In Network

Not covered

Out of Network

Not covered

Accidental injury to teeth

In Network

90% covered after deductible is met

Out of Network

60% covered after deductible is met

Surgical removal of tumors, cysts, and impacted teeth

In Network

90% covered after deductible is met

Out of Network

60% covered after deductible is met

Vision Care

Routine vision exams

In Network

Not covered

Out of Network

Not covered

Regular lenses and frames

In Network

Not covered

Out of Network

Not covered

Contact lenses

In Network

Not covered

Out of Network

Not covered

Other Services

Ambulance services

90% covered; in and out-of-network; non-emergencies not covered

Allergy tests and treatments

In Network

90% covered after deductible is met

Out of Network

60% covered after deductible is met

Durable medical equipment

In Network

90% covered after deductible is met

Out of Network

60% covered after deductible is met

Hearing Care

Hearing evaluations

In Network

90% covered; limited to one exam and \$1,000 per benefit plan year for all hearing services

Out of Network

60% covered; limited to one exam and \$1,000 per benefit plan year for all hearing services

Hearing aids

In Network

90% covered; limited to \$1,000 per benefit plan year for all hearing services

Out of Network

60% covered after deductible is met; limited to \$1,000 per benefit plan year for all hearing services

Medical Therapy

Acupuncture

In Network

90% covered after deductible is met; limited to 20 visits per benefit plan year; in and out-of-network combined

Out of Network

60% covered after deductible is met; limited to 20 visits per benefit plan year; in and out-of-network combined

Chiropractic

In Network

\$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

Out of Network

60% covered after deductible is met; limited to 40 visits per benefit plan year; in and out-of-network combined

Outpatient physical therapy

In Network

90% covered after deductible is met; limited to 50 visits per benefit plan year; in and out-of-network combined

Out of Network

60% covered after deductible is met; limited to 50 visits per benefit plan year; in and out-of-network combined

Outpatient speech therapy

In Network

90% covered after deductible is met; limited to 50 visits per benefit plan year; in and out-of-network combined

Out of Network

60% covered after deductible is met; limited to 50 visits per benefit plan year; in and out-of-network combined

Outpatient occupational therapy

In Network

90% covered after deductible is met; limited to 50 visits per benefit plan year; in and out-of-network combined

Out of Network

60% covered after deductible is met;
limited to 50 visits per benefit plan year;
in and out-of-network combined

Care at Alternate Sites

Noncustodial home health care	<p>In Network 90% covered after deductible is met; limited to 120 visits per benefit plan year; in and out-of-network combined; preauthorization required</p> <p>Out of Network 60% covered after deductible is met; limited to 120 visits per benefit plan year; in and out-of-network combined; preauthorization required</p>
Prescribed care in noncustodial skilled nursing facility	<p>In Network 90% covered after deductible is met; limited to 120 days per benefit plan year; in and out-of-network combined; preauthorization required</p> <p>Out of Network 60% covered after deductible is met; limited to 120 days per benefit plan year; in and out-of-network combined; preauthorization required</p>
Hospice care	<p>In Network 90% covered after deductible is met</p> <p>Out of Network 60% covered after deductible is met</p>

Access

	Anthem Preferred PPO
Out-of-area dependent coverage	Yes
Out-of-area participant coverage	Yes

Ease of Use

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Need to file claims	<p>In Network No</p> <p>Out of Network Yes</p>
Number of PCP changes allowed/year	Not Applicable
Ability to self-refer to OB/GYN	Yes
Ability to self-refer to specialists	Yes

Care Management: Education and Assistance

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Asthma care management	Yes
Cancer care management	Yes
Diabetes care management	Yes
Heart disease care management	Yes

Hypertension care management	Yes
Smoking cessation program	No
Weight control program	No