

# PPO<sup>+</sup> Benefit Summaries

Medical Benefits	CalChoice <sup>®</sup> PPO 750		CalChoice PPO 750 GenRx <sup>++</sup>	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible / Family Maximum	\$750 per member / \$2,250 per family	\$750 per member / \$2,250 per family	\$750 per member / \$2,250 per family	\$750 per member / \$2,250 per family
<b>DR. OFFICE VISITS</b>	<b>\$35 Copay<sup>4</sup> (ded. waived)</b>	<b>50%</b>	<b>\$35 Copay<sup>4</sup> (ded. waived)</b>	<b>50%</b>
Annual Physical Exam	100% (ded. waived)	Not Covered	100% (ded. waived)	Not Covered
Lab And X-Ray	80%	50% (Max \$800 Benefit for Advanced Imaging)	65%	50% (Max \$800 Benefit for Advanced Imaging)
<b>HOSPITAL SERVICES</b>	<b>\$500 Copay - 80%</b>	<b>50% (Up to \$650 Per Day)<sup>5</sup></b>	<b>\$500 Copay - 65%</b>	<b>50% (Up to \$650 Per Day)<sup>5</sup></b>
Inpatient Physician Fees	80%	50%	65%	50%
Emergency Room	\$150 (waived if admitted)-80%	\$150 (waived if admitted)-80%	\$150 (waived if admitted)-65%	\$150 (waived if admitted)-65%
<b>Rx BENEFITS</b>	<b>\$15 Copay</b>	<b>\$15 Copay<sup>6</sup></b>	<b>\$15 Copay<sup>8</sup></b>	<b>\$15 Copay<sup>6,8</sup></b>
Generic Formulary	<b>\$150 Ded - \$30 Copay<sup>7</sup></b>	<b>\$150 Ded - \$30 Copay<sup>6,7</sup></b>	<b>Not Covered</b>	<b>Not Covered</b>
Formulary Brand	<b>\$150 Ded - \$50 Copay<sup>7</sup></b>	<b>\$150 Ded - \$50 Copay<sup>6,7</sup></b>	<b>Not Covered</b>	<b>Not Covered</b>
Non-Formulary Brand	Covered	Covered	Covered	Covered
Oral Contraceptives	Covered as any illness	Covered as any illness	Covered as any illness	Covered as any illness
Maternity	80%	50% (Up to \$25 Per Visit) <sup>5</sup>	65%	50% (Up to \$25 Per Visit) <sup>5</sup>
Physical/Occupational Therapy and Chiropractic Care	Maximum 24 visits per year	Maximum 24 visits per year	Maximum 24 visits per year	Maximum 24 visits per year
Out-of-Pocket Max.– Ind./Fam. <sup>1</sup>	\$4,000/\$8,000 (Includes Ded)	\$10,000 per member <sup>3</sup>	\$4,500/\$9,000 (Includes Ded)	\$10,000 per member <sup>3</sup>
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Outpatient Surgery	\$500 Copay - 80%	50% (Up to \$380 Per Admission) <sup>5</sup>	\$500 Copay - 65%	50% (Up to \$380 Per Admission) <sup>5</sup>
Hospital Pre-Authorization	Required	Required or Additional \$250 Copay Applies	Required	Required or Additional \$250 Copay Applies
Hospice	100% (ded. waived)	50%	100% (ded. waived)	50%
Skilled Nursing Facility	80%	50% (Up to \$150 Per Day) <sup>5</sup>	65%	50% (Up to \$150 Per Day) <sup>5</sup>
Ambulance	Maximum 100 days per year	Maximum 100 days per year	Maximum 100 days per year	Maximum 100 days per year
Drug & Alcohol Benefits, Mental & Nervous Benefits <sup>2</sup> (severe and non-severe)	80%	50%	65%	50%
Outpatient	\$35 Copay (ded. waived)	50%	\$35 Copay (ded. waived)	50%
Inpatient	\$500 Copay - 80%	50% (Up to \$650 Per Day) <sup>5</sup>	\$500 Copay - 65%	50% (Up to \$650 Per Day) <sup>5</sup>

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# PPO

## Benefit Summaries

Medical Benefits	CalChoice® PPO 1000		CalChoice PPO 1000 GenRx <sup>††</sup>	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible / Family Maximum	\$1,000 per member / \$3,000 per family	\$1,000 per member / \$3,000 per family	\$1,000 per member / \$3,000 per family	\$1,000 per member / \$3,000 per family
<b>DR. OFFICE VISITS</b>	<b>\$40 Copay<sup>4</sup> (ded. waived)</b>	<b>50%</b>	<b>\$45 Copay<sup>4</sup> (ded. waived)</b>	<b>50%</b>
Annual Physical Exam	100% (ded. waived)	Not Covered	100% (ded. waived)	Not Covered
Lab And X-Ray	70%	50% (Max \$800 Benefit for Advanced Imaging)	55%	50% (Max \$800 Benefit for Advanced Imaging)
<b>HOSPITAL SERVICES</b>	<b>\$1,000 Copay - 70%</b>	<b>50% (Up to \$650 Per Day)<sup>5</sup></b>	<b>\$500 Copay - 55%</b>	<b>50% (Up to \$650 Per Day)<sup>5</sup></b>
Inpatient Physician Fees	70%	50%	55%	50%
Emergency Room	\$150 (waived if admitted)-70%	\$150 (waived if admitted)-70%	\$150 (waived if admitted)-55%	\$150 (waived if admitted)-55%
<b>Rx BENEFITS</b>	<b>\$15 Copay</b>	<b>\$15 Copay<sup>6</sup></b>	<b>\$15 Copay<sup>8</sup></b>	<b>\$15 Copay<sup>6,8</sup></b>
Generic Formulary	<b>\$200 Ded - \$30 Copay<sup>7</sup></b>	<b>\$200 Ded - \$30 Copay<sup>6,7</sup></b>	<b>Not Covered</b>	<b>Not Covered</b>
Formulary Brand	<b>\$200 Ded - \$50 Copay<sup>7</sup></b>	<b>\$200 Ded - \$50 Copay<sup>6,7</sup></b>	<b>Not Covered</b>	<b>Not Covered</b>
Non-Formulary Brand	Covered	Covered	Covered	Covered
Oral Contraceptives	Covered as any illness	Covered as any illness	Covered as any illness	Covered as any illness
Maternity	70% Maximum 24 visits per year	50% (Up to \$25 Per Visit) <sup>5</sup> Maximum 24 visits per year	55% Maximum 24 visits per year	50% (Up to \$25 Per Visit) <sup>5</sup> Maximum 24 visits per year
Physical/Occupational Therapy and Chiropractic Care	\$5,000/\$10,000 (Includes Ded)	\$10,000 per member <sup>3</sup>	\$5,000/\$10,000 (Includes Ded)	\$10,000 per member <sup>3</sup>
Out-of-Pocket Max. – Ind./Fam. <sup>1</sup>	Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximum	\$500 Copay - 70%	50% (Up to \$380 Per Admission) <sup>5</sup>	\$500 Copay - 55%	50% (Up to \$380 Per Admission) <sup>5</sup>
Outpatient Surgery	Required	Required or Additional \$250 Copay Applies	Required	Required or Additional \$250 Copay Applies
Hospital Pre-Authorization	100% (ded. waived)	50%	100% (ded. waived)	50%
Hospice	70% Maximum 100 days per year	50% (Up to \$150 Per Day) <sup>5</sup> Maximum 100 days per year	55% Maximum 100 days per year	50% (Up to \$150 Per Day) <sup>5</sup> Maximum 100 days per year
Skilled Nursing Facility	70%	50%	55%	50%
Ambulance	\$40 Copay (ded. waived)	50%	\$45 Copay (ded. waived)	50%
Drug & Alcohol Benefits, Mental & Nervous Benefits <sup>2</sup> (severe and non-severe)	\$1,000 Copay - 70%	50% (Up to \$650 Per Day) <sup>5</sup>	\$500 Copay - 55%	50% (Up to \$650 Per Day) <sup>5</sup>
Outpatient				
Inpatient				

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Medical Benefits	CalChoice® PPO 3000		CalChoice PPO 4000	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible / Family Maximum	\$3,000 per member / \$9,000 per family	\$3,000 per member / \$9,000 per family	\$4,000 per member / \$10,000 per family	\$4,000 per member / \$10,000 per family
<b>DR. OFFICE VISITS</b>	<b>\$30 Copay<sup>4</sup> (ded. waived)</b>	<b>50%</b>	<b>\$40 Copay<sup>4</sup> (ded. waived)</b>	<b>50%</b>
Annual Physical Exam	100% (ded. waived)	Not Covered	100% (ded. waived)	Not Covered
Lab And X-Ray	70%	50% (Max \$800 Benefit for Advanced Imaging)	60%	50% (Max \$800 Benefit for Advanced Imaging)
<b>HOSPITAL SERVICES</b>	<b>\$500 Copay - 70%</b>	<b>50% (Up to \$650 Per Day)<sup>5</sup></b>	<b>\$500 Copay - 60%</b>	<b>50% (Up to \$650 Per Day)<sup>5</sup></b>
Inpatient Physician Fees	70%	50%	60%	50%
Emergency Room	\$150 (waived if admitted)-70%	\$150 (waived if admitted)-70%	\$150 (waived if admitted)-60%	\$150 (waived if admitted)-60%
<b>Rx BENEFITS</b>	<b>\$15 Copay</b>	<b>\$15 Copay<sup>6</sup></b>	<b>\$15 Copay</b>	<b>\$15 Copay<sup>6</sup></b>
Generic Formulary	<b>\$250 Ded - \$30 Copay<sup>7</sup></b>	<b>\$250 Ded - \$30 Copay<sup>6,7</sup></b>	<b>\$250 Ded - \$30 Copay<sup>7</sup></b>	<b>\$250 Ded - \$30 Copay<sup>6,7</sup></b>
Formulary Brand	<b>\$250 Ded - \$50 Copay<sup>7</sup></b>	<b>\$250 Ded - \$50 Copay<sup>6,7</sup></b>	<b>\$250 Ded - \$50 Copay<sup>7</sup></b>	<b>\$250 Ded - \$50 Copay<sup>6,7</sup></b>
Non-Formulary Brand	Covered	Covered	Covered	Covered
Oral Contraceptives	Covered as any illness	Covered as any illness	Covered as any illness	Covered as any illness
Maternity	70% Maximum 24 visits per year	50% (Up to \$25 Per Visit) <sup>5</sup> Maximum 24 visits per year	60% Maximum 24 visits per year	50% (Up to \$25 Per Visit) <sup>5</sup> Maximum 24 visits per year
Physical/Occupational Therapy and Chiropractic Care	\$7,000/\$14,000 (Includes Ded)	\$10,000 per member <sup>3</sup>	\$7,000/\$14,000 (Includes Ded)	\$10,000 per member <sup>3</sup>
Out-of-Pocket Max. – Ind./Fam. <sup>1</sup>	Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximum	\$500 Copay - 70%	50% (Up to \$380 Per Admission) <sup>5</sup>	\$500 Copay - 60%	50% (Up to \$380 Per Admission) <sup>5</sup>
Outpatient Surgery	Required	Required or Additional \$250 Copay Applies	Required	Required or Additional \$250 Copay Applies
Hospital Pre-Authorization	100% (ded. waived)	50%	100% (ded. waived)	50%
Hospice	70% Maximum 100 days per year	50% (Up to \$150 Per Day) <sup>5</sup> Maximum 100 days per year	60% Maximum 100 days per year	50% (Up to \$150 Per Day) <sup>5</sup> Maximum 100 days per year
Skilled Nursing Facility	70%	50%	60%	50%
Ambulance	\$30 Copay (ded. waived)	50%	\$40 Copay (ded. waived)	50%
Drug & Alcohol Benefits, Mental & Nervous Benefits <sup>2</sup> (severe and non-severe)	\$500 Copay - 70%	50% (Up to \$650 Per Day) <sup>5</sup>	\$500 Copay - 60%	50% (Up to \$650 Per Day) <sup>5</sup>
Outpatient				
Inpatient				

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# PPO<sup>†</sup>

## Medical Benefit Notes

**Note:** For non-emergency care, out-of-network reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount. Non-participating hospitals are covered at a reduced benefit but there are no benefits for care in non-contracting hospitals, except for medical emergencies. For medical emergency care rendered by a non-participating provider or non-contracting hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value. Plans exclude coverage for pre-existing conditions (except for members under age 19, a child acquired through legal guardianship if the child is added within 31 days of final court decree or order, a child born to or newly adopted by an enrolled subscriber or spouse, or conditions of pregnancy) for the first six months of coverage unless replacing prior creditable coverage.

<sup>†</sup> These plans are offered by Anthem Blue Cross Life and Health Insurance Company.

<sup>\*\*</sup> Pending regulatory approval

- <sup>1</sup> The following do not apply to the out-of-pocket maximum: inpatient, outpatient and ambulatory surgical facility copays, applicable pharmacy deductibles and copays for pharmacy benefits, copays for acupuncture/acupressure, copays for not obtaining pre-service review; infertility copay; and non-covered expenses. After a member reaches the out-of-pocket maximum in a calendar year, the member will no longer be required to pay a copay for the remainder of that year, except as stated in the Certificate. The insured remains responsible for these amounts even after the out-of-pocket maximum has been met.
- <sup>2</sup> Pre-service review is required for the following mental or nervous disorders and substance abuse services; 1) Facility-based treatment or you will be required to pay a \$250 copayment if pre-service review is not obtained for non-participating providers; and 2) Outpatient professional services after twelve visits.
- <sup>3</sup> Once Anthem Blue Cross payments reach \$10,000 per insured, the insured pays nothing for covered expenses for the remainder of the year.
- <sup>4</sup> The dollar copay applies only to the visit itself. An additional copay applies for any services performed in office (i.e., x-ray, lab, surgery), after any applicable deductible.
- <sup>5</sup> The coverage amount listed is the maximum allowed charge for non-emergency services received from a non-participating hospital or non-participating provider. Members are responsible for all charges in excess of the covered amount. Physician Services are covered separately at 50% of Allowable Amounts.
- <sup>6</sup> Benefits apply to prescriptions filled at participating pharmacies. Please see Health Plan & Formulary Comparison Guide for non-participating pharmacy benefits.
- <sup>7</sup> If a member selects a brand-name drug when a generic-equivalent is available, even if the physician writes a "dispense as written" or "do not substitute", 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 pharmacy deductible, if applicable.
- <sup>8</sup> This prescription drug plan includes coverage for drugs on the GenRx Prescription Drug Formulary only.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This summary of benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

Please refer to the CaliforniaChoice<sup>®</sup> Program brochure for more detailed plan benefit information.