PPO
Benefit Summaries

Medical Benefits	CalChoice® PPO 750		CalChoice® PPO 1000	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible / Family Maximum	$750 per member, $2,250 per family		$1,000 per member, $3,000 per family	
DR. OFFICE VISITS	**$35 Copay**	**50%**	**$40 Copay**	**50%**
Annual Physical Exam	$35 Copay	Not Covered	$40 Copay	Not Covered
Lab And X-Ray	80%	50%	70%	50%
HOSPITAL SERVICES	**$500 Copay - 80%**	**Covered up to $650 per day[5]**	**$1,000 Copay - 70%**	**Covered up to $650 per day[5]**
Inpatient Physician Fees	80%	50%	70%	50%
Emergency Room	$150 (waived if admitted)-80%	$150 (waived if admitted)-80%	$150 (waived if admitted)-70%	$150 (waived if admitted)-70%
Rx BENEFITS				
Generic Formulary	**$15 Copay**	**$15 Copay[6]**	**$15 Copay**	**$15 Copay[6]**
Formulary Brand[2]	**$150 Ded - $30 Copay**	**$150 Ded - $30 Copay[6]**	**$200 Ded - $30 Copay**	**$200 Ded - $30 Copay[6]**
Non-Formulary Brand[2]	**$150 Ded - $50 Copay**	**$150 Ded - $50 Copay[6]**	**$200 Ded - $50 Copay**	**$200 Ded - $50 Copay[6]**
Oral Contraceptives	Covered	Covered	Covered	Covered
Maternity	Covered as any illness	Covered as any illness	Covered as any illness	Covered as any illness
Physical/Occupational Therapy and Chiropractic Care	80%	Covered up to $25 per visit	70%	Covered up to $25 per visit
	Maximum 24 visits per year		Maximum 24 visits per year	
Out-of-Pocket Max. – Ind./Fam.[1]	$3,750 / $7,500 (includes deductible)	$10,000 per member[4]	$4,500 / $9,000 (includes deductible)	$10,000 per member[4]
Lifetime Maximum	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Outpatient Surgery	$500 Copay - 80%	Covered up to $380 per day[5]	$500 Copay - 70%	Covered up to $380 per day[5]
Hospital Pre-Authorization	Required or additional $250 Copay applies		Required or additional $250 Copay applies	
Hospice	80%	50%	70%	50%
Skilled Nursing Facility	80%	Covered up to $150 per day[5]	70%	Covered up to $150 per day[5]
	Maximum 100 days per year		Maximum 100 days per year	
Ambulance	80%	50%	70%	50%
Drug & Alcohol Benefits, Mental & Nervous Benefits[3] (severe and non-severe)				
Outpatient	80%	Not Covered	70%	Not Covered
Inpatient	$500 Copay - 80%	Covered up to $650 per day[5]	$1,000 Copay - 70%	Covered up to $650 per day[5]

Note: Out-of-Network benefits are covered at a Negotiated Fee and members are responsible for additional amounts exceeding the Negotiated Fee rate and charges in excess of covered expenses. Plans exclude coverage for pre-existing conditions (except for pregnancy) for the first six months of coverage unless replacing prior creditable coverage.

1 The following do not apply to the out-of-pocket maximum: inpatient, outpatient and ambulatory surgical facility copays, brand name deductibles and copays for pharmacy benefits, copays for acupuncture/acupressure, copays for not obtaining pre-service review; infertility copay; and non-covered expenses. The insured remains responsible for these amounts even after the out-of-pocket maximum has been met.

2 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 brand-name deductible.

3 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; and 2) Oupatient professional services after twelve visits.

4 Once Anthem Blue Cross payments reach $10,000 per insured, the insured pays nothing for covered expenses for the remainder of the year.

5 The covered 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.

6 Benefits apply to prescriptions filled at participating pharmacies. Please see Health Plan & Formulary Comparison Guide for non-participating pharmacy benefits.

Please refer to the California*Choice*® Program brochure for more detailed plan benefit information.

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PPO
Benefit Summaries (cont.)

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		$4,000 per member, $10,000 per family	
DR. OFFICE VISITS	**$30 Copay**	**50%**	**$40 Copay**	**50%**
Annual Physical Exam	$30 Copay	Not Covered	$40 Copay	Not Covered
Lab And X-Ray	70%	50%	60%	50%
HOSPITAL SERVICES	**$500 Copay - 70%**	**Covered up to $650 per day[5]**	**$500 Copay - 60%**	**Covered up to $650 per day[5]**
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%
Rx BENEFITS				
Generic Formulary	**$15 Copay**	**$15 Copay[6]**	**$15 Copay**	**$15 Copay[6]**
Formulary Brand[2]	**$250 Ded - $30 Copay**	**$250 Ded - $30 Copay[6]**	**$250 Ded - $30 Copay**	**$250 Ded - $30 Copay[6]**
Non-Formulary Brand[2]	**$250 Ded - $50 Copay**	**$250 Ded - $50 Copay[6]**	**$250 Ded - $50 Copay**	**$250 Ded - $50 Copay[6]**
Oral Contraceptives	Covered	Covered	Covered	Covered
Maternity	Covered as any illness	Covered as any illness	Covered as any illness	Covered as any illness
Physical/Occupational Therapy and Chiropractic Care	70% Maximum 24 visits per year	Covered up to $25 per visit	60% Maximum 24 visits per year	Covered up to $25 per visit
Out-of-Pocket Max. – Ind./Fam.[1]	$7,000 / $14,000 (includes deductible)	$10,000 per member[4]	$7,000 / $14,000 (includes deductible)	$10,000 per member[4]
Lifetime Maximum	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Outpatient Surgery	$500 Copay - 70%	Covered up to $380 per day[5]	$500 Copay - 60%	Covered up to $380 per day[5]
Hospital Pre-Authorization	Required or additional $250 Copay applies		Required or additional $250 Copay applies	
Hospice	70%	50%	60%	50%
Skilled Nursing Facility	70% Maximum 100 days per year	Covered up to $150 per day[5]	60% Maximum 100 days per year	Covered up to $150 per day[5]
Ambulance	70%	50%	60%	50%
Drug & Alcohol Benefits, Mental & Nervous Benefits[3] (severe and non-severe)				
Outpatient	70%	Not Covered	60%	Not Covered
Inpatient	$500 Copay - 70%	Covered up to $650 per day[5]	$500 Copay - 60%	Covered up to $650 per day[5]

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