# ANTHEM HIGH-DEDUCTIBLE PPO 1600 MEDICAL PLAN

HIGHLIGHTED ITEMS ARE CHANGES FOR 2022

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|---|---|---|
| **Choice of Providers** | Any licensed provider. No referrals needed. If you choose a non-participating provider, you are responsible for paying billed amounts that exceed Anthem's eligible charges. (Eligible charges are determined by Anthem allowances, which are based on reasonable and customary rates for the geographic area where services are provided.) Participating providers agree to charge no more than Anthem's negotiated rates | |
| **Website** (medical and prescription drugs) | www.anthem.com/ca/caltech | |
| **Phone** (medical) | (866) 820-0765<br>For claims questions, call the customer service number on your ID card | |
| **Phone** (prescription drugs) | Anthem Pharmacy Services: (833) 261-2460<br>IngenioRx Home Delivery Pharmacy: (833) 236-6196 | |
| **ID Card** | When you first enroll, you'll receive an ID card — one card for both medical and prescription drugs — for each member of your family<br>Contact Anthem for replacement cards | |
| | **Participating Providers[1]** | **Non-Participating Providers[1]** |
| **Health Savings Account (HSA)** | You can contribute up to $3,650 for employee only coverage, $7,300 for employee + family coverage (If you are age 55 or over, you may contribute up to $1,000 more) | |
| **Annual Deductible** (per calendar year) | Includes medical and prescription drug coinsurance:<br>Employee Only Coverage Deductible: $1,600<br>Family Coverage Deductible (Employee + 1 or more dependents): $3,200 | |
| **How the Annual Deductible Works**<br>*For non-preventive care, coinsurance cost sharing begins when you reach the annual deductible* | You're responsible for the cost of all non-preventive care, including prescription drugs, up to the annual deductible.<br><br>If you enroll only yourself, the Employee Only deductible applies.<br>If you enroll yourself and one or more eligible family members, the Family deductible must be met. Under the Family deductible, the costs for all family members apply to one shared Family Deductible. | |
| **Coinsurance (Plan Pays)** | 80% of negotiated rate after deductible | 60% of eligible charges after deductible |
| **Out-of-Pocket/Copay Maximum**<br>(per calendar year) | Includes annual deductible, medical and prescription drug coinsurance, and PreventiveRx prescription drug copayments<br>Per Person: $4,000<br>Family Maximum: $8,000 | Per Person: $8,000<br>Family Maximum: $16,000 |
| **How the Out-of-Pocket Maximum Works** | Plan pays 100% of eligible expenses for covered services for the rest of the year after you reach the out-of-pocket maximum. | |
| **Prior Authorization, Preservice/Concurrent Reviews** | Required for certain procedures (e.g., bariatric weight-loss surgery, CT scans, MRIs, hospitalization). Make sure your doctor contacts Anthem before scheduling procedures; otherwise, your care may not be covered. | |
| **Coverage for Specific Services** | | |
| **Acupuncture** | 80% covered after deductible | 60% covered after deductible |
| **Allergy Test/Treatment** | 80% covered after deductible | 60% covered after deductible |
| | **Participating Providers[1]** | **Non-Participating Providers[1]** |
| **Ambulance** | 80% of eligible charges covered after deductible | 80% of eligible charges covered after deductible |
| **Chiropractic Care** | 80% covered after deductible | 60% covered after deductible |
| | Up to 24 visits per calendar year for chiropractic care, physical therapy and occupational therapy combined (participating and non-participating combined). Additional visits may be provided if authorized in advance by Anthem. | |

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| **Durable Medical Equipment/ Hearing Aids** | 80% covered after deductible | | 60% covered after deductible |
| **Emergency Room Care** | 80% of eligible charges after deductible | | |
| **Home Health Care** | 80% covered after deductible | | 60% covered after deductible |
| | Up to 120 visits per calendar year for participating and non-participating combined | | |
| **Hospice Care** | 80% covered after deductible | | 60% covered after deductible |
| **Hospitalization** | 80% covered after deductible | | 60% covered after deductible |
| | Preservice and concurrent reviews are required for hospital admissions, including residential treatment centers. If not obtained for a non-participating hospital admission, an additional $500 deductible applies. | | |
| **Blue Distinction Centers (BDC)** [6] **For: transplants, cardiac care, spine surgery, knee & hip replacements)** | **Tier 1 In-Network Blue Distinction Centers**<br>85% covered after deductible | **Tier 2 In-Network (Non-BDC)**<br>75% covered after deductible | **Tier 3 Out-of-Network Providers**<br>60% covered after deductible |
| **Infertility Diagnosis and Treatment** | $10,000 calendar year maximum<br>Outpatient and Inpatient Procedures: 80% covered after deductible<br>Imaging: Plan pays 100% after deductible | | |
| Infertility Prescription Drug Coverage | $15,000 lifetime maximum | | |
| | 47% coinsurance for generic ($50 max copay)<br>47% coinsurance for brand ($100 max copay)<br>47% coinsurance for specialty/non-preferred ($100 max copay) | | 50% coinsurance for generic ($50 max copay)<br>50% coinsurance for brand ($100 max copay)<br>50% coinsurance for specialty/non-preferred ($100 max copay)<br>(Plus, costs in excess of the Rx drug maximum allowed amount) |
| **Live Health Online** | "Telehealth" Internet chat with US board-certified doctors. Before deductible is met, you pay $59 for family medicine office visits and mental health visits range in cost depending on specialty. After deductible is met, visit is $0. Visit *www.livehealthonline.com* to lean more | | Not covered |
| **Occupational Therapy** | 80% covered after deductible | | 60% covered after deductible |
| | Up to 24 visits per calendar year for chiropractic care, physical therapy and occupational therapy combined (participating and non-participating combined). Additional visits may be provided if authorized in advance by Anthem. | | |
| **Physical Therapy** | 80% covered after deductible | | 60% covered after deductible |
| | Up to 24 visits per calendar year for chiropractic care, physical therapy and occupational therapy combined (participating and non-participating combined). Additional visits may be provided if authorized in advance by Anthem. | | |
| **Physician Office Visits** | 80% covered after deductible | | 60% covered after deductible |

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| **Pregnancy/Maternity Care** (including Routine Nursery Care) | Office visits: 80% covered after deductible<br>Inpatient hospital: 80% covered after deductible | 60% covered after deductible |
| **Prescription Drug Coverage: Retail**[5] | Up to a 30-day supply:<br>For PreventiveRx[4] drugs (deductible waived):<br>$15 copay for generic<br>$45 copay for brand-name formulary[3,4]<br>$75 copay for brand-name non-formulary[3,4]<br><br>For Non- PreventiveRx drugs (deductible[2] applies):<br>- Once the deductible is satisfied, Rx has a 20% coinsurance up to $100 per prescription for *Generic*.<br>-Once the deductible is satisfied, Rx has a 20% coinsurance up to $250 per prescription for *brand-name formulary*[3,] and *brand-name non-formulary*[3,] | Up to a 30-day supply:<br>60% covered after deductible[2] |
| | **Participating Providers**[1] | **Non-Participating Providers**[1] |
| **Prescription Drug Coverage: Mail**[5] | Up to a 90-day supply:<br>For PreventiveRx[4] drugs (deductible waived):<br>$30 copay for generic<br>$90 copay for brand-name formulary[3,4]<br>$150 copay for brand-name non-formulary[3,4]<br><br>For Non- PreventiveRx drugs (deductible[2] applies):<br>- Once the deductible is satisfied, Rx has a 20% coinsurance up to $200 per prescription for *Generic*.<br>-Once the deductible is satisfied, Rx has a 20% coinsurance up to $500 per prescription for *brand-name formulary*[3,] and *brand-name non-formulary*[3,] | Not covered |
| **Prescription Drug Specialty Pharmacy** | For up to a 30-day supply:<br>$75 copay for specialty drugs | Not Covered |
| **Preventive Care**[5]<br>• Well Baby Exams and Immunizations<br>• Annual Exams/Physicals (one per calendar year for adults and children age 3 and over)<br>• Preventive Care Tests and Screenings[5] | 100% covered (no deductible) | 60% covered after deductible |
| **Psychiatric Care: Inpatient** | 80% covered after deductible | 60% covered after deductible |

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| | Preservice and concurrent reviews are required for hospital admissions, including residential treatment centers. If not obtained for a non-participating hospital admission, an additional $500 deductible applies. | |
| **Psychiatric Care: Outpatient Day Treatment (or Outpatient Facility/Day Treatment)** | 80% covered after deductible | 60% covered after deductible |
| **Psychiatric Care: Physician Office Visits** | 80% covered after deductible | 60% covered after deductible |
| **Skilled Nursing Facility Care** | 80% covered after deductible<br>Up to 120 days per calendar year for participating and non-participating combined. | 60% covered after deductible |
| **Speech Therapy** | 80% covered after deductible | 60% covered after deductible |
| **Substance Abuse: Inpatient** | 80% covered after deductible<br>Preservice and concurrent reviews are required for hospital admissions, including residential treatment centers. If not obtained for a non-participating hospital admission, an additional $500 deductible applies. | 60% covered after deductible |
| **Substance Abuse: Outpatient Day Treatment (or Outpatient Facility/Day Treatment)** | 80% covered after deductible | 60% covered after deductible |
| **Substance Abuse: Physician Office Visits** | 80% covered after deductible | 60% covered after deductible |
| **Surgery, Outpatient** (see *Hospitalization* for inpatient surgery) | 80% covered after deductible | 60% covered after deductible |
| **Urgent Care Office Visit** | 80% covered after deductible | 60% covered after deductible |
| **Vision Exams and Materials** | Not covered in these plans.<br>Vision benefits are available through the Vision Service Plan (VSP) option. | |
| **X-ray and Lab** | 80% covered after deductible | 60% covered after deductible |

[1]**If you choose a non-participating provider, you are responsible for paying billed amounts that exceed Anthem's eligible charges. (Eligible charges are determined by Anthem allowances, which are based on reasonable and customary rates for the geographic area where services are provided.) Participating providers agree to charge no more than Anthem's negotiated rates, which are less than Anthem's eligible charges.**

[2]Preauthorization is required for some drugs. For details, check with your pharmacy, call Anthem Pharmacy Services at (833) 261-2460, or visit www.anthem.com/ca/caltech (select Pharmacy, then Prior Authorization Listing). Certain non-preferred drugs are not covered unless your physician indicates Dispense as Written (DAW) or Do Not Substitute (DNS) on the prescription. For details, visit www.anthem.com/ca/caltech (select Pharmacy, then Preferred Drug Program).

[3]If you request a brand-name drug when a generic equivalent is available, you'll pay the generic drug copay plus the difference between the price of the generic drug and the price of the brand-name drug. The price is defined as Anthem's allowed amount. If your doctor indicates Dispense as Written (DAW) on your prescription, you pay only the brand copay.

[4]PreventiveRx drugs are prescription drugs commonly used to prevent illness and other health conditions. Some are maintenance drugs used to treat conditions that are considered chronic and long-term and which require regular, daily use of medicines. Examples include drugs used to treat high blood pressure, heart disease, and asthma. Some antibiotics are

also on the PreventiveRx list. You can find the PreventiveRx list on the MyBenefits website and at www.anthem.com/ca/caltech.

[5]Preventive care coverage includes preventive services rated A or B by the U.S. Preventive Services Task Force, based on federal regulations and age and frequency guidelines. Coverage also includes certain over-the-counter prescription drugs when prescribed by your doctor and obtained at a pharmacy counter.

[6]Certain services for inpatient and surgical care have different coinsurance responsibilities available to you when those services are performed at Blue Distinction Centers. Please refer to your Anthem Evidence of Coverage booklet for the details around those services.

**For Additional Information**

For additional information, including plan limits and exclusions, see the plan's benefits booklet — also called an evidence of coverage (EOC) — on www.anthem.com/ca/caltech.

*This summary of plan benefits is not a contract. It describes benefits in general terms. Consult the individual plan booklets for specific details of benefit coverage. To permit a brief summary of benefits and services, use of actual contract language has been minimized. This summary does not replace the legal documents that establish the plans. Final interpretation of any provision of the plans will be governed by the master policies and service agreements, which are on file in the office of the plan administrator. The Institute expects and intends to continue the Caltech benefits program but reserves the right to amend, modify, suspend, or terminate it, in whole or in part, at any time and for any reason. If you are enrolled in Medicare, your Caltech medical plan coordinates with your Medicare Part A and B coverage.*