

## 2017/2018 LAPRA Medical Plans At-a-Glance

The table below provides an overview of the key benefits provided through the LAPRA medical plans. Please refer to the Anthem Blue Cross PPO or HMO, or Kaiser HMO materials for a complete description of benefits including terms of coverage, exclusions and limitations.

Benefit Feature	Anthem Blue Cross Prudent Buyer PPO		Anthem Blue Cross CaliforniaCare Plus HMO (California Residents Only)	Kaiser HMO (California Residents Only)
	PPO Network	Non-PPO Network <sup>1</sup>	HMO Providers Only <sup>3</sup>	HMO Providers Only
<b>Providers</b>				
<b>Calendar Year Deductible</b>	\$300 per person \$600 per family	\$500 per person \$1,000 per family	N/A	N/A
<b>Calendar Year Out-of-Pocket Maximum</b> (includes deductibles and co-pays; excludes co-pays for infertility benefits)	<b>Medical Charges:</b> \$2,000 per person \$6,000 per family (not to exceed \$2,000 for any one person) See page 7 for prescription drug out-of-pocket maximum.	<b>Medical Charges:</b> \$3,000 per person \$9,000 per family (not to exceed \$3,000 for any one person) See page 7 for prescription drug out-of-pocket maximum.	<b>Medical and Prescription Drug Charges:</b> \$1,000 per person \$3,000 per family	<b>Medical and Prescription Drug Charges:</b> \$1,500 per person \$3,000 per family
<b>Lifetime Max</b>	Unlimited		Unlimited	Unlimited
<b>Office Visit</b>	90% <sup>2</sup>	70% <sup>2</sup>	\$15 co-pay	\$15 co-pay
<b>Hospitalization</b>	90% <sup>2</sup>	70% <sup>2,4,5</sup>	100%	100%
<b>Emergency Room</b>	90% <sup>2</sup> after a \$150 co-pay (waived if admitted)		\$150 co-pay (waived if admitted)	\$150 co-pay (waived if admitted)
<b>Urgent Care</b>	90% <sup>2</sup>	70% <sup>2</sup>	\$15 co-pay	\$15 co-pay
<b>Maternity Care</b>	90% <sup>2</sup>	70% <sup>2</sup>	Doctor visits: \$15 co-pay (initial visit only) Facility charges: 100%	Doctor visits: 100% Facility charges: 100%
<b>Well Baby/ Child Care</b>	100% (up to age 7; not subject to deductible)	70% <sup>2</sup> (up to age 7; not subject to deductible)	100% (up to age 7)	100% (up to age 2)
<b>Routine Physical</b>	100% (adults & children over age 7; not subject to deductible)	Not covered	100% (adults & children over age 7)	100%
<b>Diagnostic X-ray &amp; Lab Tests</b>	90% <sup>2</sup>	70% <sup>2</sup>	100%	100%
<b>Body Scans</b> (not subject to deductible)	100% after \$25 co-pay; up to \$250 per calendar yr	Not Covered	Not Covered	Not Covered
<b>Physical &amp; Occupational Therapy and Chiropractic Services</b> (additional services may be authorized)	90% <sup>2</sup> (24 visits per calendar yr combined PPO Network & Non-PPO Network)	70% <sup>2</sup> (24 visits per calendar yr combined PPO Network & Non-PPO Network)	\$15 co-pay (limited to a 60-day period of care after illness or injury; additional visits available when approved by the medical group)	\$15 co-pay (Chiropractic up to 40 visits per year)
<b>Acupuncture</b>	90% <sup>2</sup> (24 visits per calendar yr combined PPO Network & Non-PPO Network)	70% <sup>2</sup> (24 visits per calendar yr combined PPO Network & Non-PPO Network)	\$15 co-pay	\$15 co-pay
<b>Mental Health/ Chemical Dependency</b>				
• Outpatient	90% <sup>2</sup>	70% <sup>2</sup>	\$15 co-pay	\$15 co-pay individual therapy/ group therapy: \$7 co-pay mental health, \$5 co-pay chem dep
• Inpatient	90% <sup>2</sup>	70% <sup>2,4,5</sup>	100%	100%

<sup>1</sup> Benefits are based on the customary and reasonable charge. You are responsible for any difference between the amount charged and the customary and reasonable charge, plus any deductible and/or coinsurance amount.

<sup>2</sup> Subject to calendar year deductible.

<sup>3</sup> Your primary care physician can refer you to a specialist when necessary and must approve all care you receive except in the event of an emergency.

<sup>4</sup> Failure to obtain pre-service authorization may result in a \$350 penalty.

<sup>5</sup> Covered expense is reduced by 25% for services and supplies provided by a non-contracting hospital.