Anthem HMO Benefit Highlights
University of Southern California

This is a brief overview of your plan's benefits. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Annual copay maximum: Individual $1,500; Two-Party $3,000; Family (3+) $4,500

Covered Services	Per Member Copay
Preventive Care Services	No copay
Physician Medical Services • Office & home visits • Specialists	 $20/visit $20/visit
Outpatient Medical Services (*Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital*) • Outpatient surgery & supplies • Advanced Imaging • All other X-ray & laboratory tests (*including genetic testing*) • Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy • Other Outpatient Medical Services including: Rehabilitation Therapy (Physical, Occupational, or Speech Therapy, limited to a 60-day period of care)	 $250 copay per admit $100 copay per test No copay $20 per visit $20 per visit
General Medical Services (*when performed in non-hospital-based facility*) • Advanced Imaging • All other X-ray & laboratory tests (*including genetic testing*) • Allergy testing & treatment (including serums) • Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy • Rehabilitation Therapy (Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care)	 $100/test No copay $20 per visit $20 per visit $20 per visit
Emergency Care • Physician & medical services • Outpatient hospital emergency room services	 No copay $150 copay (*waived if admitted inpatient*)
Inpatient Medical Services Semi-private room or private room, medically necessary services & supplies	$250 copay per admit
Urgent Care (out of service area)	$30 per visit
Ambulance Services • Transportation when medically necessary	No copay
Ambulatory Surgical Center • Outpatient surgery & supplies	$250 copay per admit
Pregnancy and Maternity Care Prenatal & postnatal Professional (physician) services (For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)	$20 per visit

Covered Services	Per Member Copay
Durable Medical Equipment (*hearing aids benefit is available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	No copay
Family Planning Services • Infertility studies & tests • Female Sterilization *(including tubal ligation and counseling/consultation)* • Male Sterilization	 50% of covered expense† No copay $50 copay
Prescription Drugs **Retail Participating Pharmacy** ○ Preventive immunizations administered by a retail pharmacy ○ Female oral contraceptives generic and single source brand ○ Generic Drugs ○ Brand name formulary drugs ○ Brand name non-formulary drugs ○ Self-administered injectable drugs, except insulin	 No copay No copay $10 copay 20% with a minimum $30 copay, $125 maximum 45% with a minimum $50 copay, $250 maximum $200 copay
Specialty Pharmacy Drugs (may only be obtained through the specialty pharmacy program) ○ Generic drugs ○ Brand name formulary drugs ○ Brand name non-formulary drugs ○ Self-administered injectable drugs, except insulin	 $20 copay $25 copay 45% with a minimum $50 copay, $250 maximum $200 copay
Mental or Nervous Disorders and Substance Abuse • Inpatient facility care *(subject to utilization review; waived for emergency admission)* • Inpatient physician visits • Outpatient facility care • Physician office visits (*Behavioral Health Treatment for Autism or Pervasive Development Disorders require pre-service review)*	 $250 copay per admit No copay $20 copay $20 copay
Organ and Tissue Transplant • Inpatient Care • Physician office visits • Specialist office visits	 $250 copay per admit $20 per visit $20 per visit

For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_HMO

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