Feature	PacifiCare EPO of Southern CA
Provider	PacifiCare of California 1-800-908-9185 www.pacificare.com/ngc
	Cost Sharing
Annual Deductible	$0 Individual; $0 Family
Out-of-pocket maximum	$0 Individual; $0 Family
Lifetime coverage limit	$2,000,000; for all Northrop Grumman-sponsored medical plan options; retiree and active combined
	Policies/Requirements
Need to file claims	No; except for out-of-network or emergency care
Domestic partner benefits	Yes
	Access
Ability to self-refer to OB/GYN	Yes
Ability to self-refer to specialists	Yes
Out-of-area dependent coverage	No
Out-of-area participant coverage	No
	Spending Account
You only	Not applicable
You and spouse	Not applicable
You and child	Not applicable
You and family	Not applicable
Eligible expenses for reimbursement	Not applicable
	Outpatient Services
Primary doctor office visit	$20 copay
Specialist doctor office visit	$40 copay
	Preventive Care
Annual physical exam	$20 copay PCP; $40 copay specialist
Well-woman exam (includes pap)	$20 copay PCP; $40 copay specialist
Mammogram	100% covered; age schedules apply; check with Plan for details
Pediatric exams	$20 copay PCP; $40 copay specialist
Immunizations (child)	Included with office visit copay
Colonoscopy	100% covered
Cancer screenings	Included with office visit copay
Cardiovascular screenings	Included with office visit copay
Allergy tests and treatments	$20 copay; PCP; $40 copay specialist
	Outpatient Care
Outpatient surgery	100% covered
Outpatient laboratory services	100% covered; physician's office; $20 copay at outpatient network laboratories
Outpatient physical therapy	$20 copay; limited to 50 visits per benefit plan year
Outpatient X-ray	100% covered; physician's office; $20 copay at outpatient network laboratories
Outpatient occupational therapy	$20 copay; limited to 50 visits per benefit plan year
Outpatient speech therapy	$20 copay; limited to 50 visits per benefit plan year
Outpatient cardiac rehabilitation	$20 copay; limited to Phase 1 and Phase 2 care
	Family Planning/Maternity Care
Office visit: pre/postnatal	$20 copay initial visit only; PCP; $40 copay specialist initial visit only

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In-hospital delivery services	$200 copay; per admission
Newborn nursery services	100% covered; after inpatient hospital copay
Fertility services	100% covered; after applicable copays; limited to $12,500 per lifetime including prescription drugs
In vitro fertilization	100% covered; after applicable copays; limited to $12,500 per lifetime for all fertility services combined including prescription drugs
Artificial insemination	100% covered; after applicable copays; limited to $12,500 per lifetime for all fertility services combined including prescription drugs
Female tubal ligation	100% covered; outpatient hospital setting; $20 copay PCP/$40 copay specialist in office setting; $200 copay inpatient hospital setting
Male vasectomy	100% covered; outpatient hospital setting; $20 copay PCP/$40 copay specialist in office setting; $200 copay inpatient hospital setting
	Hearing
Hearing evaluations	$20 copay; PCP; $40 copay specialist; limited to one exam per benefit year
Hearing aids	Limited to $1,000 per benefit plan year; check with Plan for limitations
	Vision
Routine vision exams	$20 copay; limited to PCP screening only, limited to one exam per benefit plan year
Regular lenses and frames	Not covered
Contact lenses	Not covered
	Dental
Dental implants	Not covered
Accidental injury to teeth	Coverage based on place of service; check with Plan for details
Surgical removal of tumors, cysts and impacted teeth	Coverage based on place of service; limited to removal of malignant tumors affecting teeth; check with Plan for details
	Inpatient Services
Hospital copay	$200 copay per admission
Hospital semi-private room	100% covered after inpatient hospital copay
Inpatient lab and X-ray	100% covered after inpatient hospital copay
Inpatient surgery	100% covered after inpatient hospital copay
Inpatient physician and surgeon services	100% covered after inpatient hospital copay
	Emergency Care
Emergency room (not followed by admission)	$250 copay
Urgent care clinic visit	$20 copay
Ambulance services	100% covered
	Prescription Drug Coverage
Annual prescription deductible	Not applicable
Prescription drug website	Same as medical plan
Prescription drug member services	Same as medical plan
Prescription drug vendor	Same as medical plan
Annual Rx out-of-pocket maximum	$1,500 Individual; $3,000 Family
	Retail
Retail generic	$5 copay or 10% coinsurance whichever is greater; 30 day supply

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Retail formulary brand	$20 copay or 10% coinsurance whichever is greater; 30 day supply; chemically equivalent generics required; check with Plan for details
Retail nonformulary brand	$40 copay or 10% coinsurance whichever is greater; 30 day supply; chemically equivalent generics required; check with Plan for details
	Mail Order
Mail order generic	$5 copay or 10% coinsurance whichever is greater; 90 day supply; mail order required for maintenance medications; check with Plan for details
Mail order formulary brand	$20 copay or 10% coinsurance whichever is greater; 90 day supply; chemically equivalent generics required; mail order required for maintenance medications; check with Plan for details
Mail order nonformulary brand	$40 copay or 10% coinsurance whichever is greater; 90 day supply; chemically equivalent generics required; mail order required for maintenance medications; check with Plan for details
	Other
Oral contraceptives	Retail and mail order available; applicable prescription drug copay applies
Fertility drugs	100% covered; after applicable copays; formulary applies; limited to $12,500 per lifetime for all fertility services combined
Injectables	Applicable prescription drug copay applies; formulary applies
	Mental Health
Mental Health: Combined with substance abuse	Yes
Mental Health: Outpatient coverage	$20 copay; limited to 60 individual, group, or family visits per benefit plan year
Mental Health: Inpatient coverage	$200 copay per admission; limited to 60 days per benefit plan year
	Substance Abuse
Detox: Outpatient coverage	$20 copay; limited to 60 individual, group or family visits per benefit plan year
Detox: Inpatient coverage	$200 copay per admission; limited to 60 days per benefit plan year; limited to two inpatient admissions per lifetime
Rehab: Outpatient coverage	$20 copay; limited to 60 individual, group, or family visits per benefit plan year
Rehab: Inpatient coverage	$200 copay per admission; limited to 60 days per benefit plan year; limited to two inpatient admissions per lifetime
	Alternative Care
Chiropractic	$40 copay; limited to 40 visits per benefit plan year; PCP referral not required at participating providers
Acupuncture	$40 copay; limited to 20 visits per benefit year; PCP referral not required at participating providers
	Care Management Programs
Heart disease care management	Yes
Hypertension care management	Yes
Diabetes care management	Yes
Asthma care management	Yes
Prenatal care management	Yes
Cancer care management	Yes

Feature	PacifiCare EPO of Southern CA
Smoking cessation program	Yes
Weight control program	Yes
	Other
Noncustodial home health care	100% covered; limited to 120 visits per benefit plan year
Hospice care	100% covered
Prescribed care in noncustodial skilled nursing facility	100% covered; limited to 120 visits per benefit plan year
Durable medical equipment	100% covered; must be medically necessary
Prosthetic devices	100% covered; must be medically necessary