Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross EPO - Non-California*	
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Plan Changes are in Orange	**2027 In-Network**	**2027 Comments**
General Information		
Lifetime Maximum Benefit	N/A	
Annual Maximum Benefit	N/A	
Coinsurance Percentage	90%	Changed 100% coinsurance to 90%
Precertification Requirements	Precertification is required for certain services.	
Precertification Penalty	No Penalty	
Health Savings Account (HSA)	N/A	
Health Reimbursement Account (HRA)	N/A	
R & C	N/A	
Deductibles		
Individual Annual Deductible	$125	
Family Annual Deductible	$250	
Applies to Out-of-Pocket Maximum	Yes	
Prescription benefits are covered under medical deductible	Yes	
Out-of-Pocket Mx per Plan Year		
Individual Out-of-Pocket Maximum Per Year	$3,000.00	
Family Out-of-Pocket Maximum Per Year	$6,000.00	
Outpatient Services[1]		
Primary Care Physician Visits	$20 copay	
Specialist Visit	$35 copay	
Lab tests and X-ray	90.00%	
Specialized Imaging	$100 copay	
Outpatient Surgery	90.00%	
Allergy Testing	90.00%	
Allergy Injections	90.00%	
Preventive Care		
Well Child Care Office Visit	100.00%	
Well Child Age limit	through age 18	
Adult Routine Physical Exams	100.00%	
Adult Immunizations	100.00%	
Routine Mammogram	100.00%	
Pap Smear	100.00%	
Prostate Screening (PSA)	100.00%	
Colon Cancer Screenings	100.00%	
Cardiovascular screenings	100.00%	
Hearing Evaluations	100.00%	
Inpatient Hospital		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Hospital Services	90.00%	
Physicians and Surgeons' Services	90.00%	
Emergency Services		
Emergency Room Treatment	$75 copay	
Non-emergency or non-urgent use of ER	$75 copay	
Ambulance	100.00%	
Urgent Care Facility Services	$20 copay if services billed as office visit. If facility located and billed by a hospital, then ER copay applies.	
Physician Office Visit	$20 copay	
After Hours	$20 copay	
Maternity Care		
Physician Office Visit	$20 copay Copayment applies to initial office visit ONLY.	
Maternity Care - Inpatient Delivery	90.00%	
Midwife delivery services	90.00%	

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Mental Health		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Mental Health Inpatient	90.00%	
Mental Health-Inpatient Plan Maximums	N/A	
Mental Health Outpatient	$20 copay	
Mental Health - Group Therapy	$20 copay	
Mental Health-Outpatient Plan Maximums	N/A	
Severe Mental Illness	$20 copay applies for professional office visits; outpatient paid at 90%	
Substance Abuse		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Detoxification	90.00%	
Substance Abuse - Inpatient Treatment	90.00%	
Substance Abuse-Inpatient Plan Maximums	N/A	
Substance Abuse-Outpatient	$20 copay	
Substance Abuse-Outpatient Plan Maximums	N/A	
Rehabilitation Therapy		
Inpatient Rehabilitation	90.00%	
Outpatient Physical, Occupational, and Speech Therapy	90% 60 visits per calendar year combined for Physical Therapy, Occupational Therapy, Chiropractic and Acupuncture)	
Alternative Care		
Chiropractic Care	$20 copay 60 visits per calendar year combined for Physical Therapy, Occupational Therapy, Chiropractic and Acupuncture)	
Acupuncture	$20 copay 60 visits per calendar year combined for Physical Therapy, Occupational Therapy, Chiropractic and Acupuncture)	
Acupressure	Not covered	
Massage Therapy	Not Covered	
Other Services		
Private-Duty Nursing Care	Not covered	
Durable Medical Equipment	90.00%	
Prosthetic and Orthotic Appliances	90.00%	
Smoking Cessation	Not covered	
Weight control program	Not covered	
Bariatric surgery	90.00%	
TMJ	90.00%	
Podiatry Services	$20 PCP copay $35 SPC copay	
Home Health Care	90.00%	
Skilled Nursing Facility Care	90% up to 100 days per calendar year	
Hospice Care	90.00%	
Hearing Aids	90% limited to one hearing aid per ear every three years; up to a maximum of $3000 limit per ear.	
Family Planning		
Tubal ligation	$0 copay	
Vasectomy	$50 copay	
Contraceptive Drugs	Covered under pharmacy benefit	
Contraceptive Devices	90.00%	
Infertility Testing	50.00%	

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Infertility Treatments - Office Visit	50.00%	
Infertility Treatments - Surgery	Not covered	
In Vitro Fertilization	Not covered	
Infertility Treatments - Lifetime Maximum	Not covered	
Vision Care		
Eye Examination	$35 copay	
Lenses	Not covered	
Frames	Not covered	
Contact lenses- necessary	Not covered	
Contact lenses-elective	Not covered	
Lasik Eye Surgery	Not covered	
Organ and Tissue Transplants		
Organ Transplant -Inpatient	90.00%	
Organs covered	90.00%	
Transplant Travel	90% subject to limitations	
Transplant donor expenses		
Lifetime Maximum	N/A	
Prescription Drug Coverage		
Annual Prescription Deductible - Family	N/A	
Annual Prescription Deductible - Individual	N/A	
Out-of-Pocket Maximums - Individual	$3,600.00	
Out-of-Pocket Maximums - Family	$7,200.00	
Annual Maximum Benefit	N/A	
Lifetime Maximum Benefit	N/A	
Generic Substitution	N/A	
Retail Refill Penalty	N/A	
Prescription Drug Retail		
Retail - Generic	$10 copay	
Retail - Brand Formulary	20% ($30 min / $60 max)	
Retail - Brand Non-Formulary	50% ($60 min / $120 max)	
Single Source Brand	Subject to applicable formulary* or non-formulary copay	
Multi Source Brand	Subject to applicable formulary* or non-formulary copay	
Specialty Injectable Medications	20% up $100 copay maximum for Self-Injectable Specialty medications only	
Prescription Drug Mail Order		
Mail-Order - Generic	$20 copay	Also, applies for Smart90 (CVS and Walgreens)
Mail-Order - Brand Formulary	20% ($60 min / $120 max)	Also, applies for Smart90 (CVS and Walgreens)
Mail-Order - Brand Non-Formulary	50% ($120 min / $240 max)	Also, applies for Smart90 (CVS and Walgreens)
Single Source Brand	Subject to applicable formulary* or non-formulary copay	
Multi Source Brand	Subject to applicable formulary* or non-formulary copay	
Specialty Injectable Medications	20% up $100 copay maximum for Self-Injectable Specialty medications only	
Day Supply	Non-Specialty - 90 Day; Specialty - 30 Day	
Other Services - Prescription Drugs		
Over the Counter	Exclusion	
Prenatal Vitamins	Subject to applicable formulary* or non-formulary copays	
Diabetic Supplies	$0 copay for preferred strips; regular copay for supplies	

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Lifestyle Drugs	Subject to applicable formulary* or non-formulary copays; may be subject to prior authorization	
Contraceptives - Injectable	$0 copay per ACA guidelines	
Fertility Drugs	Exclusion	
Smoking Cessation	$0 copay per ACA guidelines	
Cosmetic Medications	Exclusion	
Nutritional Supplements	Metabolic Infant Formula only.	

[1] Increase the existing copay for PCP and SPC office visits by $10 when using non-Diamond providers