Medicare Eligible / Over 65 Only	Anthem Blue Cross Senior Secure HMO - Southern CA*	
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Plan Changes are in Orange	**2027 Current Benefits**	**2027 Comments**
General Information		
Lifetime Maximum Benefit	None	
Annual Maximum Benefit	None	
Coinsurance Percentage	N/A	
Precertification Requirements	Prior authorization is required for select services. Services must be coordinated by your primary care physician. (Refer to the Benefit Chart/EOC)	
Precertification Penalty	N/A	
Health Savings Account (HSA)	N/A	
Health Reimbursement Account (HRA)	N/A	
R & C	N/A	
Deductibles		
Individual Annual Deductible	$0.00	
Family Annual Deductible	N/A	
Applies to Out-of-Pocket Maximum	N/A	
Prescription benefits are covered under medical deductible	No	
Out-of-Pocket Mx per Plan Year		
Individual Out-of-Pocket Maximum Per Year	$3,400.00	
Family Out-of-Pocket Maximum Per Year	N/A	
Outpatient Services		
Primary Care Physician Visits	$10 copay	
Specialist Visit	$10 copay	
Lab tests and X-ray	$0 copay for each Medicare-covered x-ray visit $0 copay for each Medicare-covered clinical/diagnostic lab test	
Specialized Imaging	$0 copay for Medicare-covered complex diagnostic test/ radiology visit	
Outpatient Surgery	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery	
Allergy Testing	$10 copay per visit including the office visit	
Allergy Injections	$10 copay per visit including the office visit	
Preventive Care		
Well Child Care Office Visit	N/A	
Well Child Age limit	N/A	
Adult Routine Physical Exams	$0 copay	
Adult Immunizations	$0 copay	
Routine Mammogram	$0 copay	
Pap Smear	$0 copay	
Prostate Screening (PSA)	$0 copay	
Colon Cancer Screenings	$0 copay	
Cardiovascular screenings	$0 copay	
Hearing Evaluations	$0 copay for routine hearing exams and limited to 1 every calendar year.	
Inpatient Hospital		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Hospital Services	$0 copay per admission	
Physicians and Surgeons' Services	$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	

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Emergency Services		
Emergency Room Treatment	$20 copay for each Medicare-covered emergency room visit Copay is waived if admitted within 72 hours for the same condition	
Non-emergency or non-urgent use of ER	Emergency care coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States	
Ambulance	$0 copay for Medicare-covered ambulance services per one-way trip	
Urgent Care Facility Services	$10 copay for each Medicare-covered urgently needed care visit Copay is waived if admitted within 72 hours for the same condition	
Physician Office Visit	$10 copay primary care physician $10 copay specialist	
After Hours	$10 copay primary care physician $10 copay specialist	
Maternity Care		
Physician Office Visit	$10 copay primary care physician $10 copay specialist	
Maternity Care - Inpatient Delivery	Benefits depend upon the type of Medicare-covered services rendered	
Midwife delivery services	Benefits depend upon the type of Medicare-covered services rendered	
Mental Health		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Mental Health Inpatient	$0 copay per admission	
Mental Health-Inpatient Plan Maximums	None	
Mental Health Outpatient	$0 copay for each Medicare-covered outpatient hospital facility visit for individual therapy, group therapy or partial hospitalization	
Mental Health - Group Therapy	$10 copay for each Medicare-covered professional individual therapy, group therapy or partial hospitalization visit	
Mental Health-Outpatient Plan Maximums	None	
Severe Mental Illness	Covered based on Medicare guidelines	
Substance Abuse		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Detoxification	Covered based on Medicare guidelines	
Substance Abuse - Inpatient Treatment	$0 copay per admission	
Substance Abuse-Inpatient Plan Maximums	None	
Substance Abuse-Outpatient	$0 copay for each Medicare-covered outpatient hospital facility visit for individual therapy, group therapy or partial hospitalization	
Substance Abuse-Outpatient Plan Maximums	None	
Rehabilitation Therapy		
Inpatient Rehabilitation	$0 copay per admission	
Outpatient Physical, Occupational, and Speech Therapy	$10 copay for Medicare-covered visits	

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Alternative Care		
Chiropractic Care	$10 copay for each Medicare-covered visit Additional Chiro: $10 copay per visit and limited to 20 visits per year. $0 copay for appliances and limited to a benefit maximum of $50 per year.	
Acupuncture	$10 copay	
Acupressure	Not covered	
Massage Therapy	Not covered	
Other Services		
Private-Duty Nursing Care	Not covered	
Durable Medical Equipment	$0 copay for Medicare-covered DME including oxygen supplies and oxygen	
Prosthetic and Orthotic Appliances	$0 copay on all Medicare-covered prosthetics and orthotics	
Smoking Cessation	$0 copay for each Medicare-covered counseling quit attempt	
Weight control program	Not covered	
Bariatric surgery	Covered based on Medicare guidelines	
TMJ	Covered based on Medicare guidelines	
Podiatry Services	$10 copay for each Medicare-covered visit. Routine Foot Care - $10 copay. Up to 12 covered visits per year.	
Home Health Care	$0 copay	
Skilled Nursing Facility Care	$0 copay for days 1-100 per benefit period	
Hospice Care	$10 copay for the one time only hospice consultation	
Hearing Aids	$0 copay. Hearing aids are limited to a $500 maximum benefit every calendar year Must use a Hearing Care Solutions participating provider	
Family Planning		
Tubal ligation	Not covered	
Vasectomy	Not covered	
Contraceptive Drugs	Not covered, unless prescription is covered under the pharmacy formulary	
Contraceptive Devices	Covered under Part D. Applicable copays apply.	
Infertility Testing	Covered based on Medicare guidelines to determine a diagnosis of infertility	
Infertility Treatments - Office Visit	Not covered	
Infertility Treatments - Surgery	Not covered	
In Vitro Fertilization	Not covered	
Infertility Treatments - Lifetime Maximum	Not covered	
Vision Care		
Eye Examination	$0 copay for routine vision exams and limited to once every calendar year. $10 copay for primary care physician visits and $10 copay for specialist visits to diagnose and treat diseases of the eye	Must use a Blue View Vision provider
Lenses	$0 copay for eyeglass lenses limited to one pair of standard plastic prescription lenses, once every calendar year	Must use a Blue View Vision provider

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Frames	$100 allowance towards the purchase of frames and limited to one pair of eyeglass frames, once every two calendar years	Must use a Blue View Vision provider
Contact lenses- necessary	$0 copay for glasses/contacts following Medicare-covered cataract surgery Medicare guidelines apply	Must use a Blue View Vision provider.
Contact lenses-elective	$100 allowance towards the purchase of elective contact lenses limited to once every calendar year.	Must use a Blue View Vision provider.
Lasik Eye Surgery	Not covered	
Organ and Tissue Transplants		
Organ Transplant -Inpatient	$0 copay per admission	
Organs covered	Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell and intestinal/Mult visceral.	
Transplant Travel	Covered based on Medicare guidelines	
Transplant donor expenses	Covered based on Medicare guidelines	
Lifetime Maximum	None	
Prescription Drug Coverage		
Annual Prescription Deductible - Family	N/A	
Annual Prescription Deductible - Individual	$0.00	
Out-of-Pocket Maximums - Individual	$2,000.00	
Out-of-Pocket Maximums - Family	N/A	
Annual Maximum Benefit	None	
Lifetime Maximum Benefit	None	
Generic Substitution	N/A	
Retail Refill Penalty	N/A	
Prescription Drug Retail		
Retail - Generic	$0 copay for Select Generics $10 copay for Generics	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Retail - Brand Formulary	$20 copay	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.

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Retail - Brand Non-Formulary	$40 copay	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Single Source Brand	Applicable copays apply	
Multi Source Brand	Applicable copays apply	
Injectable Medications	Applicable copays apply	
Prescription Drug Mail Order		
Mail-Order - Generic	$0 copay for Select Generics $20 copay for Generics	
Mail-Order - Brand Formulary	$40 copay	
Mail-Order - Brand Non-Formulary	$80 copay	
Single Source Brand	Applicable copays apply	
Multi Source Brand	Applicable copays apply	
Injectable Medications	Applicable copays apply	
Day Supply	90-day	
Other Services - Prescription Drugs		
Over the Counter	Not covered	
Prenatal Vitamins	Applicable copays apply. See Drug List for complete list of drugs covered.	
Diabetic Supplies	If purchased through a pharmacy: $0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU CHECK® (made by Roche Diagnostics) $10 copay for all other brands when purchased through the pharmacy	
Lifestyle Drugs	Applicable copays apply. See Drug List for complete list of drugs covered.	
Contraceptives - Injectable	$20 copay per covered device. Please see Drug List for complete list of drugs covered	
Fertility Drugs	Not covered	
Smoking Cessation	$0 copay for each Medicare-covered counseling quit attempt	
Cosmetic Medications	Not covered	
Nutritional Supplements	Not covered	