

Active Employees & Pre-65 Retirees  
(Non-Medicare Only)

**EPO - Anthem - Non-California**

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	2020 In-Network	Comments
<b>General Information</b>		
Lifetime Maximum Benefit	N/A	
Annual Maximum Benefit	N/A	
Coinsurance Percentage	100.00%	
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	
<b>Deductibles</b>		
Individual Annual Deductible	N/A	
Family Annual Deductible	N/A	
Applies to Out-of-Pocket Maximum	N/A	
Prescription benefits are covered under medical deductible	N/A	
<b>Out-of-Pocket Mx per Plan Year</b>		
Individual Out-of-Pocket Maximum Per Year	\$3,000.00	
Family Out-of-Pocket Maximum Per Year	\$6,000.00	
<b>Outpatient Services</b>		
Primary Care Physician Visits	\$20 copay	
Specialist Visit	\$35 copay	
Lab tests and X-ray	100.00%	
Specialized Imaging	\$100 copay	
Outpatient Surgery	100.00%	
Allergy Testing	100.00%	
Allergy Injections	100.00%	
<b>Preventive Care</b>		
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%	
<b>Inpatient Hospital</b>		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Hospital Services	100.00%	
Physicians and Surgeons' Services	100.00%	
<b>Emergency Services</b>		
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	

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<b>Maternity Care</b>		
Physician Office Visit	\$20 copay Copayment applies to initial office visit ONLY.	
Maternity Care - Inpatient Delivery	100.00%	
Midwife delivery services	100.00%	
<b>Mental Health</b>		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Mental Health Inpatient	100.00%	
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 100%	
<b>Substance Abuse</b>		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Detoxification	100.00%	
Substance Abuse - Inpatient Treatment	100.00%	
Substance Abuse-Inpatient Plan Maximums	N/A	
Substance Abuse-Outpatient	\$20 copay	
Substance Abuse-Outpatient Plan Maximums	N/A	
<b>Rehabilitation Therapy</b>		
Inpatient Rehabilitation	100.00%	
Outpatient Physical, Occupational, and Speech Therapy	100% 60 visits per calendar year combined for Physical Therapy, Occupational Therapy, Chiropractic and Acupuncture)	
<b>Alternative Care</b>		
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	
<b>Other Services</b>		
Private-Duty Nursing Care	Not covered	
Durable Medical Equipment	100.00%	
Prosthetic and Orthotic Appliances	100.00%	
Smoking Cessation	Not covered	
Weight control program	Not covered	
Bariatric surgery	100.00%	
TMJ	100.00%	
Podiatry Services	\$20 PCP copay \$35 SPC copay	
Home Health Care	100.00%	
Skilled Nursing Facility Care	100% up to 100 days per calendar year	
Hospice Care	100.00%	
Hearing Aids	100% limited to one hearing aid per ear every three years; up to a maximum of \$3000 limit per ear.	

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<b>Family Planning</b>		
Tubal ligation	\$0 copay	
Vasectomy	\$50 copay	
Contraceptive Drugs	Covered under pharmacy benefit	
Contraceptive Devices	100.00%	
Infertility Testing	50.00%	
Infertility Treatments - Office Visit	50.00%	
Infertility Treatments - Surgery	Not covered	
In Vitro Fertilization	Not covered	
Infertility Treatments - Lifetime Maximum	Not covered	
<b>Vision Care</b>		
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	
<b>Organ and Tissue Transplants</b>		
Organ Transplant -Inpatient	100.00%	
Organs covered	100.00%	
Transplant Travel	100% subject to limitations	
<b>Transplant donor expenses</b>		
Lifetime Maximum	N/A	
<b>Prescription Drug Coverage</b>		
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	
<b>Prescription Drug Retail</b>		
Retail - Generic	\$10 copay	
Retail - Brand Formulary	\$30 copay	
Retail - Brand Non-Formulary	\$60 copay	
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	
<b>Prescription Drug Mail Order</b>		
Mail-Order - Generic	\$20 copay	
Mail-Order - Brand Formulary	\$60 copay	
Mail-Order - Brand Non-Formulary	\$120 copay	
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	

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<b>Other Services - Prescription Drugs</b>		
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	
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.	
Details		