Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross EPO - Non-California*
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Plan Changes are in Orange	**2021 In-Network**
General Information	
Lifetime Maximum Benefit	N/A
Annual Maximum Benefit	N/A
Coinsurance Percentage	100%
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	N/A
Family Annual Deductible	N/A
Applies to Out-of-Pocket Maximum	N/A
Prescription benefits are covered under medical deductible	N/A
Out-of-Pocket Mx per Plan Year	
Individual Out-of-Pocket Maximum Per Year	$3,000
Family Out-of-Pocket Maximum Per Year	$6,000
Outpatient Services	
Primary Care Physician Visits	$20 copay
Specialist Visit	$35 copay
Lab tests and X-ray	100%
Specialized Imaging	$100 copay
Outpatient Surgery	100%
Allergy Testing	100%
Allergy Injections	100%
Preventive Care	
Well Child Care Office Visit	100%
Well Child Age limit	through age 18
Adult Routine Physical Exams	100%
Adult Immunizations	100%
Routine Mammogram	100%
Pap Smear	100%
Prostate Screening (PSA)	100%
Colon Cancer Screenings	100%
Cardiovascular screenings	100%
Hearing Evaluations	100%
Inpatient Hospital	
Deductible per Confinement	N/A
Deductible per Day	N/A
Hospital Services	100%
Physicians and Surgeons' Services	100%
Emergency Services	
Emergency Room Treatment	$75 copay
Non-emergency or non-urgent use of ER	$75 copay
Ambulance	100%
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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Plan Changes are in Orange	**2021 In-Network**
Maternity Care	
Physician Office Visit	$20 copay Copayment applies to initial office visit ONLY.
Maternity Care - Inpatient Delivery	100%
Midwife delivery services	100%
Mental Health	
Deductible per Confinement	N/A
Deductible per Day	N/A
Mental Health Inpatient	100%
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%
Substance Abuse	
Deductible per Confinement	N/A
Deductible per Day	N/A
Detoxification	100%
Substance Abuse - Inpatient Treatment	100%
Substance Abuse-Inpatient Plan Maximums	N/A
Substance Abuse-Outpatient	$20 copay
Substance Abuse-Outpatient Plan Maximums	N/A
Rehabilitation Therapy	
Inpatient Rehabilitation	100%
Outpatient Physical, Occupational, and Speech Therapy	100% 60 visits per calendar year combined for Physical Therpay, Occupational Therpay, Chiropractic and Acupunture)
Alternative Care	
Chiropractic Care	$20 copay 60 visits per calendar year combined for Physical Therpay, Occupational Therpay, Chiropractic and Acupunture)
Acupuncture	$20 copay 60 visits per calendar year combined for Physical Therpay, Occupational Therpay, Chiropractic and Acupunture)
Acupressure	Not covered
Massage Therapy	Not Covered

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Plan Changes are in Orange	**2021 In-Network**
Other Services	
Private-Duty Nursing Care	Not covered
Durable Medical Equipment	100%
Prosthetic and Orthotic Appliances	100%
Smoking Cessation	Not covered
Weight control program	Not covered
Bariatric surgery	100%
TMJ	100%
Podiatry Services	$20 PCP copay $35 SPC copay
Home Health Care	100%
Skilled Nursing Facility Care	100% up to 100 days per calendar year
Hospice Care	100%
Hearing Aids	100% 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	100%
Infertility Testing	50%
Infertility Treatments - Office Visit	50%
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	100%
Organs covered	100%
Transplant Travel	100% 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
Out-of-Pocket Maximums - Family	$7,200
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	$30 copay
Retail - Brand Non-Formulary	$60 copay
Single Source Brand	Subject to applicable formulary* or non-formularycopay
Multi Source Brand	Subject to applicable formulary* or non-formulary copay

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Plan Changes are in Orange	**2021 In-Network**
Specialty Injectable Medications	20% up $100 copay maximum for Self-Injectable Specialty medications only
Prescription Drug Mail Order	
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
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
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.