Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross HMO - California*	
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Plan Changes are in Orange	**2025 In-Network**	**2025 Comments**
General Information		
Lifetime Maximum Benefit	N/A	
Annual Maximum Benefit	N/A	
Coinsurance Percentage	100.00%	
Precertification Requirements	Pre-certification is required for certain services. However, this is an HMO Plan and the member must be referred by Primary Care Physicians for all services or those services will not be covered.	
Precertification Penalty	Services will be denied if pre-certification is not obtained, unless services are related to emergency.	
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	$3,000.00	
Family Out-of-Pocket Maximum Per Year	$6,000.00	
Outpatient Services		
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% (If billed for an office visit; an applicable copayment will apply.)	
Allergy Injections	100% (Serum is covered at 100%)	
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	100.00%	
Physicians and Surgeons' Services	100.00%	
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.	

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Physician Office Visit	$20 copay	
After Hours	$20 copay	
Maternity Care		
Physician Office Visit	$20 copay	
Maternity Care - Inpatient Delivery	100.00%	
Midwife delivery services	100.00%	
Mental Health		
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%	
Substance Abuse		
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	
Rehabilitation Therapy		
Inpatient Rehabilitation	100.00%	
Outpatient Physical, Occupational, and Speech Therapy	100% limited to a 60-day period of care after an illness or injury; additional visits available if approved by medical group	
Alternative Care		
Chiropractic Care	$20 copay - must be ordered by Primary Care Physician and approved by Medical Group	
Acupuncture	$20 copay; PCP referral required	
Acupressure	Not covered	
Massage Therapy	Not Covered	
Other Services		
Private-Duty Nursing Care	Not covered	
Durable Medical Equipment	100.00%	No calendar year maximum.
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%	(Inpatient or outpatient services for members; family bereavement services)
Hearing Aids	100% limited to one hearing aid per ear every three years	
Family Planning		
Tubal ligation	No copayment	
Vasectomy	$50 copay	

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Plan Changes are in Orange	**2025 In-Network**	**2025 Comments**
Contraceptive Drugs	Covered under pharmacy benefit	
Contraceptive Devices	100.00%	
Infertility Testing	50% does not apply to the Out of Pocket Maximum	Medical care that is covered, when provided for the diagnosis and treatment of infertility, shall be those services and supplies specified in the Evidence of Coverage (EOC) as covered for the treatment of illness generally. The member must be under the direct care and treatment of a physician for infertility. Benefits are NOT payable for laboratory medical procedures involving the actual in vitro fertilization process.
Infertility Treatments - Office Visit	50% does not apply to the Out of Pocket Maximum	Medical care that is covered, when provided for the diagnosis and treatment of infertility, shall be those services and supplies specified in the Evidence of Coverage (EOC) as covered for the treatment of illness generally. The member must be under the direct care and treatment of a physician for infertility. Benefits are NOT payable for laboratory medical procedures involving the actual in vitro fertilization process.
Infertility Treatments - Surgery	Not covered	
In Vitro Fertilization	Not covered	
Infertility Treatments - Lifetime Maximum	Not covered	
Vision Care		
Eye Examination	$20 copay PCP/ $35 Specialist	(vision screening from primary care physician covers evaluation only; diagnostic & treatment programs, including refraction, from an optometrist or ophthalmologist must be authorized by primary care physician)
Lenses	Not covered	(eyeglasses and contact lenses needed after cataract surgery are covered)
Frames	Not covered	(eyeglasses and contact lenses needed after cataract surgery are covered)
Contact lenses- necessary	100.00%	(eyeglasses and contact lenses needed after cataract surgery are covered)
Contact lenses-elective	Not covered	
Lasik Eye Surgery	Not covered	
Organ and Tissue Transplants		
Organ Transplant -Inpatient	100.00%	
Organs covered	100.00%	
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	$3,600.00	
Out-of-Pocket Maximums - Family	$7,200.00	
Annual Maximum Benefit	N/A	
Lifetime Maximum Benefit	N/A	
Generic Substitution	N/A	

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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 copay	
Multi Source Brand	Subject to applicable formulary copay	
Injectable Medications	20% up $100 copay maximum	
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	Copay determined by formulary	
Multi Source Brand	Copay determined by formulary	
Injectable Medications	20% up $100 copay maximum	
Day Supply	90 Day	
Other Services - Prescription Drugs		
Over the Counter	Exclusion	
Prenatal Vitamins	Rx Only	
Diabetic Supplies	Regular copays	
Lifestyle Drugs	Regular copays	
Contraceptives - Injectable	Exclusion	
Fertility Drugs	Exclusion	
Smoking Cessation	Exclusion	
Cosmetic Medications	Exclusion	
Nutritional Supplements	Metabolic Infant Formula only.	