Active Employees and Pre-65 Retirees	Anthem Blue Cross HMO - California*
(Niew Medicare Order)	Antifem Blac 01033 mile Gamorna

Plan Changes are in Orange 2025 In-Network 2025 Comments	Benefits Department.		
Lifetime Maximum Benefit Annual Maximum Benefit Coinsurance Percentage Precertification Requirements Precertification Requirements Precertification Requirements Precertification Requirements Precertification 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 Reimbursement Account (HRA) N/A N/A R & C N/A Deductibles Individual Annual Deductible Applies to Out-of-Pocket Maximum Prescription benefits are covered under medical deductible Out-of-Pocket Maximum Per Year Individual Out-of-Pocket Maximum Per Year Individual Out-of-Pocket Maximum Per Year Services Primary Care Physician Visits S20 copay Specialist Visit S35 copay Lab tests and X-ray Specialist Visit S35 copay Lab tests and X-ray Specialist Visit S36 copay Allergy Testing 100% (If billed for an office visit; an applicable copayment will apply.) Allergy Injections 100.00% Preventive Care Well Child Care Office Visit Well Child Age limit through age 18 Adult Routine Physician Fox Individual Surveys 100.00% Preventive Care Well Child Care Office Visit Hearting Evaluations 100.00% Cardiovascular screenings 100.00%		2025 In-Network	2025 Comments
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Cardiovascular screenings 100.00% Hearing Evaluations 100.00% Inpatient Hospital			
Hearing Evaluations 100.00% Inpatient Hospital	Cardiovascular screenings		
		100.00%	
	Inpatient Hospital		
Deductible per Confinement N/A	Deductible per Confinement	N/A	
Deductible per Day N/A	Deductible per Day	N/A	
Hospital Services 100.00%			
Physicians and Surgeons' Services 100.00%		100.00%	
Emergency Services	Emergency Services		
Emergency Room Treatment \$75 copay	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.	Urgent Care Facility Services		
If facility located and billed by a hospital,			
then ER copay applies.		then ER copay applies.	

Active Employees and Pre-65 Retirees	Anthem Blue Cross HMO - California*
(Non Madiagra Only)	Anthem Blue Cross HMO - Californ

Benefits Department.	, , , , , , , , , , , , , , , , , , ,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Plan Changes are in Orange	2025 In-Network	2025 Comments
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	100.0070	
	N/A	
Deductible per Confinement	N/A	
Deductible per Day Mental Health Inpatient	-	
	100.00% N/A	
Mental Health-Inpatient Plan Maximums		
Mental Health Outpatient Mental Health - Group Therapy	\$20 copay	
	\$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	N/A	
Maximums		
Substance Abuse-Outpatient	\$20 copay	
Substance Abuse-Outpatient Plan	N/A	
Maximums		
Rehabilitation Therapy		
Inpatient Rehabilitation	100.00%	
Outpatient Physical, Occupational, and	100% limited to a 60-day period of care	
Speech Therapy	after an illness or injury; additional visits	
Горосон тногару	available if approved by medical group	
Alternative Care	aranasis ii approvos sy iiisaisai gisap	
Chiropractic Care	\$20 copay - must be ordered by Primary	
Chilopractic Gare	Care Physician and approved by Medical	
A communications	Group	
Acuprocaure	\$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	Operations of the state of the
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	

Active Er	nployees	and	Pre-65	Retirees
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Anthem Blue Cross HMO - California*

Benefits Department.		
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	\$7,200.00 N/A	
Lifetime Maximum Benefit	N/A	
Generic Substitution	N/A	

Active Employees and Pre-65 Retirees
(Niew Medicana Only)

Anthem Blue Cross HMO - California*

Plan Changes are in Orange	2025 In-Network	2025 Comments
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.	