Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross PPO - Nationwide*		
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Plan Changes are in Orange	**2025 In-Network**	**2025 Out-of-Network**	**2025 Comments**
General Information			
Lifetime Maximum Benefit	Unlimited	Unlimited	
Annual Maximum Benefit	Unlimited	Unlimited	
Coinsurance Percentage	80.00%	50.00%	
Precertification Requirements			
Precertification Penalty	Covered benefits reduced by 30% if no precertification obtained where required	Covered benefits reduced by 30% if no precertification obtained where required	
Health Savings Account (HSA)	N/A	N/A	
Health Reimbursement Account (HRA)	N/A	N/A	
R & C	N/A	Applies to Non-Contracted Providers	
Deductibles			
Individual Annual Deductible	$500, (Does not apply to Out-of-Network)	$750, applies to In-Network	
Family Annual Deductible	$1,500 (Does not apply to Out-of-Network)	$2,250 applies to In-Network	
Applies to Out-of-Pocket Maximum	Yes	Yes	
Prescription benefits are covered under medical deductible	RX Deductible does not apply to medical deductible.	RX Deductible does not apply to medical deductible.	
Out-of-Pocket Mx per Plan Year	See Individual and Family Out of Pocket	See Individual and Family Out of Pocket	
Individual Out-of-Pocket Maximum Per Year	$3,000 (Out of Pocket amounts accumulate separately for In and Out of Network)	$9,000 (Out of Pocket amounts accumulate separately for In and Out of Network)	
Family Out-of-Pocket Maximum Per Year	$6,000 (Out of Pocket amounts accumulate separately for In and Out of Network)	$18,000 (Out of Pocket amounts accumulate separately for In and Out of Network)	
Outpatient Services			
Primary Care Physician Visits	$20 copay	50.00%	
Specialist Visit	$35 copay	50.00%	
Lab tests and X-ray	80.00%	50.00%	
Specialized Imaging	80.00%	50.00%	
Outpatient Surgery	80.00%	50.00%	
Allergy Testing	80.00%	50.00%	
Allergy Injections	80.00%	50.00%	
Preventive Care			
Well Child Care Office Visit	100.00%	50.00%	
Well Child Age limit	to age 19	to age 19	
Adult Routine Physical Exams	100.00%	50.00%	
Adult Immunizations	100.00%	50.00%	
Routine Mammogram	100.00%	50.00%	
Pap Smear	100.00%	50.00%	
Prostate Screening (PSA)	100.00%	50.00%	
Colon Cancer Screenings	100.00%	50.00%	
Cardiovascular screenings	100.00%	50.00%	
Hearing Evaluations	100.00%	50.00%	
Inpatient Hospital			
Deductible per Confinement	N/A	N/A	
Deductible per Day	N/A	N/A	
Hospital Services	80% - Pre-authorization required for all inpatient admissions.	50% - Pre-authorization required for all inpatient admissions.	
Physicians and Surgeons' Services	80.00%	50.00%	
Emergency Services			
Emergency Room Treatment	$150, Waived if admitted	$150, Waived if admitted	
Non-emergency or non-urgent use of ER	80.00%	50.00%	
Ambulance	80.00%	80% Emergencies Only	
Urgent Care Facility Services	$20 copay	50.00%	
Physician Office Visit	$20 copay	50.00%	
After Hours	$20 copay	50.00%	
Maternity Care			
Physician Office Visit	$20 copay Copayment applies to initial office visit ONLY.	50.00%	
Maternity Care - Inpatient Delivery	80.00%	50.00%	
Midwife delivery services	80.00%	50.00%	
Mental Health			
Deductible per Confinement	N/A	N/A	
Deductible per Day	N/A	N/A	
Mental Health Inpatient	80% - Pre-authorization required for all inpatient admissions	50% - Pre-authorization required for all inpatient admissions	
Mental Health-Inpatient Plan Maximums	None	None	
Mental Health Outpatient	$20 copay	50.00%	
Mental Health - Group Therapy	$20 copay	50.00%	
Mental Health-Outpatient Plan Maximums	None	None	
Severe Mental Illness	80.00%	50.00%	
Substance Abuse	80.00%	50.00%	
Deductible per Confinement	N/A	N/A	

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Plan Changes are in Orange	**2025 In-Network**	**2025 Out-of-Network**	**2025 Comments**
Deductible per Day	N/A	N/A	
Detoxification	80.00%	50.00%	
Substance Abuse - Inpatient Treatment;	80% - Pre-authorization required for all inpatient admissions	50% - Pre-authorization required for all inpatient admissions	
Substance Abuse-Inpatient Plan Maximums	None	None	
Substance Abuse-Outpatient	$20 copay	50.00%	
Substance Abuse-Outpatient Plan Maximums	None	None	
Rehabilitation Therapy			
Inpatient Rehabilitation	80.00%	50.00%	
Outpatient Physical, Occupational, and Speech Therapy	80.00%	50.00%	
Alternative Care			
Chiropractic Care	80% up to 24 visits per calendar year. Visit max combined for Physical Therapy, Occupational Therapy, Acupuncture	50% up to 24 visits per calendar year. Visit max combined for Physical Therapy, Occupational Therapy, Acupuncture	
Acupuncture	80% Combined max with Chiropractic Care, Physical Therapy, Occupational Therapy. Additional 10 visits allowed	50% Combined max with Chiropractic Care, Physical Therapy, Occupational Therapy. Additional 10 visits allowed	
Acupressure	Not covered	Not covered	
Massage Therapy	Covered only as part of office visit to a licensed chiropractor or physical therapist .	Covered only as part of office visit to a licensed chiropractor or physical therapist .	
Other Services			
Private-Duty Nursing Care	Not covered	Not covered	
Durable Medical Equipment	80.00%	50.00%	
Prosthetic and Orthotic Appliances	80.00%	50.00%	
Smoking Cessation	Not covered	Not covered	
Weight control program	Not covered	Not covered	
Bariatric surgery	80% - requires utilization review; covered only at COE	Not covered	
TMJ	80.00%	50.00%	
Podiatry Services	80.00%	50.00%	
Home Health Care	100% up to 180 visits combined in and out of network	50% up to 180 visits combined in and out of network	
Skilled Nursing Facility Care	80% up to 180 visits combined in and out of network	50% up to 180 visits combined in and out of network	
Hospice Care	100%, deductible does not apply	50.00%	
Hearing Aids	80% (Limit of one every 3 years)	50% (Limited of one every 3 years)	
Family Planning			
Tubal ligation	100% no deductible	50.00%	
Vasectomy	80.00%	50.00%	
Contraceptive Drugs	Not covered unless prescription is covered under the pharmacy formulary.	N/A	
Contraceptive Devices	100% no deductible	50.00%	
Infertility Testing	Not covered	Not covered	
Infertility Treatments - Office Visit	Not covered	Not covered	
Infertility Treatments - Surgery	Not covered	Not covered	
In Vitro Fertilization	Not covered	Not covered	
Infertility Treatments - Lifetime Maximum	N/A	N/A	
Vision Care			
Eye Examination	Not covered	Not covered	
Lenses	80% Covered after cataract surgery	50% Covered after cataract surgery	
Frames	80% Covered after cataract surgery	50% Covered after cataract surgery	
Contact lenses- necessary	80% Covered after cataract surgery	50% Covered after cataract surgery	
Contact lenses-elective	Not covered	Not covered	
Lasik Eye Surgery	Not covered	Not covered	
Organ and Tissue Transplants			
Organ Transplant -Inpatient	80.00%	Not covered	
Organs covered	80.00%	Not covered	
Transplant Travel	Covered benefit for specialized transplants performed at a designated COE facility: benefit limitations may apply	Covered benefit for specialized transplants performed at a designated COE facility: benefit limitations may apply	
Transplant donor expenses	Covered; subject to plan limitations	Covered; subject to plan limitations	
Lifetime Maximum	N/A	N/A	
Prescription Drug Coverage			
Annual Prescription Deductible - Family	N/A	N/A	
Annual Prescription Deductible - Individual	$200 Brand Name Drugs Only	$200 Brand Name Drugs Only	
Out-of-Pocket Maximums - Individual	$3,600, combined for in and out of network	$3,600, combined for in and out of network	

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Plan Changes are in Orange	**2025 In-Network**	**2025 Out-of-Network**	**2025 Comments**
Out-of-Pocket Maximums - Family	$7,200, combined for in and out of network	$7,200, combined for in and out of network	
Annual Maximum Benefit	N/A	N/A	
Lifetime Maximum Benefit	N/A	N/A	
Generic Substitution	N/A	N/A	
Retail Refill Penalty	N/A	N/A	
Prescription Drug Retail			
Retail - Generic	$5 copay	$5 copay, then 50% of the cost of the medication	
Retail - Brand Formulary	$30 copay, after $200 brand deductible	$30 copay, then 50% of the cost of the medication after $200 brand deductible	
Retail - Brand Non-Formulary	$60 copay, after $200 brand deductible	$60 copay, then 50% of the cost of the medication after $200 brand deductible	
Single Source Brand	Subject to applicable formulary/non-formulary copay after brand deductible	Subject to applicable formulary/non-formulary copay after brand deductible	
Multi Source Brand	Subject to applicable formulary/non-formulary copay after brand deductible	Subject to applicable formulary/non-formulary copay after brand deductible	
Injectable Medications	20% up $100 copay maximum for Self-Injectable Specialty medications only	20% up $100 copay maximum for Self-Injectable Specialty medications only	
Prescription Drug Mail Order			
Mail-Order - Generic	$10 copay	Not covered	Also, applies for Smart90 (CVS and Walgreens)
Mail-Order - Brand Formulary	$60 copay, after $200 brand deductible	Not covered	Also, applies for Smart90 (CVS and Walgreens)
Mail-Order - Brand Non-Formulary	$120 copay, after $200 brand deductible	Not covered	Also, applies for Smart90 (CVS and Walgreens)
Single Source Brand	Subject to applicable formulary/non-formulary copay after brand deductible	Not covered	
Multi Source Brand	Subject to applicable formulary/non-formulary copay after brand deductible	Not covered	
Injectable Medications	20% up $100 copay maximum	Not covered	
Day Supply	Non-Specialty - 90 Day; Specialty - 30 Day	Not covered	
Other Services - Prescription Drugs			
Over the Counter	Not covered	Not covered	
Prenatal Vitamins	Rx Only	Rx Only	
Diabetic Supplies	$0 copay for preferred strips; regular copay for supplies	Regular copays plus 50% of the maximum allowed amount plus any costs over the allowed amount	
Lifestyle Drugs	Regular copays; may be subject to prior authorization	Regular copays plus 50% of the maximum allowed amount plus any costs over the allowed amount	
Contraceptives - Injectable	$0 copay per ACA guidelines	Not covered	
Fertility Drugs	Not covered	Not covered	
Smoking Cessation	$0 copay per ACA guidelines	Not covered	
Cosmetic Medications	Not covered	Not covered	
Nutritional Supplements	Metabolic Infant Formula only.	Metabolic Infant Formula only.	