Active Employees	Anthem Blue Cross Basic CDHP*		
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Plan Changes are in Orange	**2026 In-Network**	**2026 Out-of-Network**	**Comments**
General Information			
Lifetime Maximum Benefit	Unlimited	Unlimited	
Annual Maximum Benefit	Unlimited	Unlimited	
Coinsurance Percentage	70%	50%	
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)	No	No	
Health Reimbursement Account (HRA)	No	No	
R & C	N/A	Applies to Non-Contracted Providers	
Deductibles			
Individual Annual Deductible	$3,000 (Does not apply to Out-of-Network)	$6,000 applies to In-Network	
Family Annual Deductible	$6,000 (Does not apply to Out-of-Network)	$12,000 applies to In-Network	**embedded; in-network dedeductible is embedded at $3,400 per individual**
Deductible applies to Out-of-Pocket Maximu	Yes	Yes	
Prescription benefits are covered under med	No	No	
Out-of-Pocket Mx per Plan Year			
Individual Out-of-Pocket Maximum Per Year	$5,000 (Out of Pocket amounts accumulate separately for In and Out of Network)	$10,000 (Out of Pocket amounts accumulate separately for In and Out of Network)	
Family Out-of-Pocket Maximum Per Year	$10,000 (Out of Pocket amounts accumulate separately for In and Out of Network)	$20,000 (Out of Pocket amounts accumulate separately for In and Out of Network)	embedded
Outpatient Services			
Primary Care Physician Visits	70%	50%	
Specialist Visit	70%	50%	
Lab tests and X-ray	70%	50%	
Specialized Imaging	70%	50%	
Outpatient Surgery	70%	50%	
Allergy Testing	70%	50%	
Allergy Injections	70%	50%	
Preventive Care			
Well Child Care Office Visit	100%	50%	
Well Child Age limit	to age 19	to age 19	
Adult Routine Physical Exams	100%	50%	
Adult Immunizations	100%	50%	
Routine Mammogram	100%	50%	
Pap Smear	100%	50%	
Prostate Screening (PSA)	100%	50%	
Colon Cancer Screenings	100%	50%	
Cardiovascular screenings	100%	50%	
Hearing Evaluations	100%	50%	
Inpatient Hospital			
Deductible per Confinement	N/A	N/A	
Copay per Day	N/A	N/A	
Hospital Services	70% - Pre-authorization required for all inpatient admissions.	50% - Pre-authorization required for all inpatient admissions.	
Physicians and Surgeons' Services	70%	50%	
Emergency Services			
Emergency Room Treatment	70%	70%	
Non-emergency or non-urgent use of ER	70%	50%	
Ambulance	70%	70% Emergencies Only	
Urgent Care Facility Services	70%	50%	
Physician Office Visit	70%	50%	
After Hours	70%	50%	
Maternity Care			
Physician Office Visit	70%	50%	
Maternity Care - Inpatient Delivery	70%	50%	
Midwife delivery services	70%	50%	
Mental Health			
Deductible per Confinement	N/A	N/A	
Copay per Day	N/A	N/A	
Mental Health Inpatient	70% - 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	70%	50%	
Mental Health - Group Therapy	70%	50%	
Mental Health-Outpatient Plan Maximums	None	None	
Severe Mental Illness	70%	50%	
Substance Abuse			
Deductible per Confinement	N/A	N/A	
Copay per Day	N/A	N/A	
Detoxification	70%	50%	
Substance Abuse - Inpatient Treatment	70% - Pre-authorization required for all inpatient admissions	50% - Pre-authorization required for all inpatient admissions	
Substance Abuse-Inpatient Plan Maximums	None	None	

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Substance Abuse-Outpatient	70%	50%	
Substance Abuse-Outpatient Plan Maximum	None	None	
Rehabilitation Therapy			
Inpatient Rehabilitation	70%	50%	
Outpatient Physical, Occupational, and Spee	70%	50%	
Alternative Care			
Chiropractic Care	70%	50%	
Acupuncture	70%	50%	
Acupressure	70%	50%	
Massage Therapy	70%	50%	
Other Services			
Private-Duty Nursing Care	Not covered	Not covered	
Durable Medical Equipment	70%	50%	
Prosthetic and Orthotic Appliances	70%	50%	
Smoking Cessation	Not covered	Not covered	
Weight control program	Not covered	Not covered	
Bariatric surgery	70% - requires utilization review; covered only at COE	Not covered	
TMJ	70%	50%	
Podiatry Services	70%	50%	
Home Health Care	70% 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	70% up to 180 visits combined in and out of network	50% up to 180 visits combined in and out of network	
Hospice Care	70%, deductible does not apply	50%	
Hearing Aids	70% (Limit of one every 3 years)	50%	
Family Planning			
Tubal ligation	70%	50%	
Vasectomy	70%	50%	
Contraceptive Drugs	Not covered unless prescription is covered under the pharmacy formulary.	N/A	
Contraceptive Devices	70%	50%	
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	70% Covered after cataract surgery	50% Covered after cataract surgery	
Frames	70% Covered after cataract surgery	50% Covered after cataract surgery	
Contact lenses- necessary	70% 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	70%	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 - Individual	$3,0000 (integrated with medical)	N/A	
Annual Prescription Deductible - Family	$6,000 (integrated with medical)	N/A	**embedded; in-network dedeductible is embedded at $3,400 per individual**
Out-of-Pocket Maximums - Individual	$5,000 (integrated with medical)	N/A	
Out-of-Pocket Maximums - Family	$10,000 (integrated with medical)	N/A	embedded
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	$10 copay	Not Covered	
Retail - Brand Formulary	30% $30 min/ $60 max	Not Covered	
Retail - Brand Non-Formulary	50% $60 min/ $120 max	Not Covered	
Single Source Brand	ct to applicable formulary* or non-formulary	Not Covered	
Multi Source Brand	ct to applicable formulary* or non-formulary	Not Covered	
Injectable Medications	20% up $100 copay maximum	Not Covered	
Prescription Drug Mail Order			
Mail-Order - Generic	$20 copay	Not Covered	Also, applies for Smart90 (CVS and Walgreens)
Mail-Order - Brand Formulary	30% $60 min/ $120 max	Not Covered	Also, applies for Smart90 (CVS and Walgreens)
Mail-Order - Brand Non-Formulary	50% $120 min/ $240 max	Not Covered	Also, applies for Smart90 (CVS and Walgreens)

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Single Source Brand	Subject to applicable formulary* or non-formulary copay	Not Covered	
Multi Source Brand	Subject to applicable formulary* or non-formulary copay	Not Covered	
Injectable Medications	20% up $100 copay maximum for All Specialty	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	Not Covered	
Diabetic Supplies	$0 copay for preferred strips; regular copay for supplies	Not Covered	
Lifestyle Drugs	Regular copays; may be subject to prior authorization	Not Covered	
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.	Not Covered	