Active Employees and Pre-65 Retirees
(Non-Medicare Only)

Anthem Blue Cross HMO - California*

Benefits Department.		
Plan Changes are in Orange	2026 In-Network	2026 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	
December of the December	those services will not be covered.	
Precertification Penalty	Services will be denied if pre-certification is not obtained, unless services are related to	
	'	
Health Savings Account (HSA)	emergency. 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	N/A	
medical deductible		
Out-of-Pocket Mx per Plan Year		
Individual Out-of-Pocket Maximum Per	\$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 Prostate Screening (PSA)	100.00% 100.00%	
Colon Cancer Screenings	100.00%	
Cardiovascular screenings	100.00%	
Hearing Evaluations	100.00%	
Inpatient Hospital	100.00 /0	
Deductible per Confinement	N/A	
Deductible per Commement Deductible per Day	N/A N/A	
Hospital Services	100.00%	
Physicians and Surgeons' Services	100.00%	
Emergency Services	10010070	
Emergency Room Treatment	\$75 copay	
Non-emergency or non-urgent use of ER	\$75 copay	
Ambulance	100.00%	
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Urgent Care Facility Services \$20 copay fservices billed as office visit. If facility located and billed by a hospital, then ER copay applies ### S20 copay ### Maternity Care Physician Office Visit \$20 copay	Plan Changes are in Orange	2026 In-Network	2026 Comments
facility located and billed by a hospital, then	Plan Changes are in Orange		2026 Comments
ER copay applies. Physician Office Visit S20 copay After Hours S20 copay Maternity Care Physician Office Visit S20 copay Maternity Care - Inpatient Delivery Maternity Care - Inpatient Delivery Maternity Care - Inpatient Delivery Moving delivery services 100.00% Moving Care - Inpatient Delivery Moving Care - Inpatient Delive	orgeni Care Facility Services		
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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 service		100.00%	
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 service	Podiatry Services	\$20 PCP copay \$35 SPC copay	
Skilled Nursing Facility Care 100% up to 100 days per calendar year Hospice Care 100.00% (Inpatient or outpatient services for members; family bereavement service			
Hospice Care 100.00% (Inpatient or outpatient services for members; family bereavement service		100% up to 100 days per calendar vear	
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Hearing Aids 100% limited to one hearing aid per ear			members; family bereavement services)
every three years	Hearing Aids		

Active Employees and Pre-65 Retirees (Non-Medicare Only)

Anthem Blue Cross HMO - California*

Benefits Department.			
Plan Changes are in Orange	2026 In-Network	2026 Comments	
Family Planning			
Tubal ligation	No copayment		
Vasectomy	\$50 copay		
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	
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.	
Infertility Treatments - Surgery	Subject to SB729	Due to SB729, the Anthem HMO covers three IVF cycles and unlimited embryo transfers.	
In Vitro Fertilization	Subject to SB729	Due to SB729, the Anthem HMO covers three IVF cycles and unlimited embryo transfers.	
Infertility Treatments - Lifetime Maximum	Subject to SB729	Due to SB729, the Anthem HMO covers three IVF cycles and unlimited embryo transfers.	
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	
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		

Active Employees and Pre-65 Retirees (Non-Medicare Only)

Anthem Blue Cross HMO - California*

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Plan Changes are in Orange	2026 In-Network	2026 Comments
Out-of-Pocket Maximums - Family	\$7,200.00	
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 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.	