2027 Medical Plan Comparison Chart

Compare features of our medical plans. Plans with in- and out-of-network benefits will display a column for each level of coverage. ***See below for prescription drug coverage.***

	ANTHEM $100 DEDUCTIBLE SELECT PPO		ANTHEM $100 DEDUCTIBLE CLASSIC PPO		ANTHEM DEDUCTIBLE CLASSIC PPO**	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Network Name		N/A		N/A		N/A
Accumulation Period	Calendar year from January 1 through December 31		Calendar year from January 1 through December 31		Calendar year from January 1 through December 31	
Calendar Year Deductible Individual Coverage Family Coverage	$100 per individual $200 per family	$100 per individual $200 per family	$100 per individual $200 per family	$100 per individual $200 per family	$2,500 per individual $3,500 per individual/$5,000 per family	$2,500 per individual $3,500 per individual/$5,000 per family
Calendar Year Out-of-Pocket Max Individual Coverage Family Coverage	$2,100 per individual $4,200 per family	$2,100 per individual $4,200 per family	$2,100 per individual $4,200 per family	$2,100 per individual $4,200 per family	$4,000 per individual $4,000 per individual/$8,000 per family	$9,000 per individual $9,000 per individual/$18,000 per family
Office Visit Primary Care/Specialist Online Visit/Telehealth	$25 copay $25 copay	30%* 30%*	$25 copay $25 copay	30%* 30%*	20%* 20%*	40%* 40%*
Preventive Services	No charge	30%*	No charge	30%*	No charge	40%*
Urgent Care	$25 copay	30%*	$25 copay	30%*	20%*	40%*
Emergency Room	$100 copay*	$100 copay*	$100 copay*	$100 copay*	20%*	20%*
Lab and Imaging Basic/Complex	10%*/10%*	30%*; outside facility limit up to $350 / 30%*; advanced imaging limit up to $800 per service	10%*/10%*	30%*; outside facility limit up to $350 / 30%*; advanced imaging limit up to $800 per service	20%*/20%*	40%*; outside facility limit up to $350 / 40%*; advanced imaging limit up to $800 per service
Ambulance Services	10%*		10%*		No charge	
Chiropractic / Acupuncture	10%* (20 visits each)	30%* (20 visits each)	10%* (20 visits each)	30%* (20 visits each)	20%* (20 visits each)	40%* (20 visits each)
Annual Eye Exam	No charge	30%*	No charge	30%*	No charge	40%*
Outpatient Surgery/Services	$100 copay + 10% after deductible	30%*	$100 copay + 10% after deductible	30%*	20%*	40%*
Inpatient Hospitalization	10%*	30%*; non-emergency inpatient max payment $1,000/day	10%*	30%*; non-emergency inpatient max payment $1,000/day	20%*	40%*; non-emergency inpatient max payment $1,000/day
Prescription Drug Benefits						
Calendar Year Deductible	N/A	N/A	N/A	N/A	Combined with medical deductible	Combined with medical deductible
Calendar Year Out-of-Pocket Max	Combined with medical OOP	Combined with medical OOP	Combined with medical OOP	Combined with medical OOP	Combined with medical OOP	Combined with medical OOP
Retail (30 Day)/Mail Order (90 Day) Tier 1 - Generic Tier 2 - Preferred Brand Tier 3 - Non-Preferred Specialty	$10 retail / $20 mail order $25 retail / $50 mail order $40 retail / $80 mail order Same as Tier 3: $40 retail / $80 mail order	**All Tiers + Specialty:** 25% up to $250 retail / mail order not covered	$10 retail / $20 mail order $25 retail / $50 mail order $40 retail / $80 mail order Same as Tier 3: $40 retail / $80 mail order	**All Tiers + Specialty:** 25% up to $250 retail / mail order not covered	$10 retail / $20 mail order $30 retail / $60 mail order $60 retail / $120 mail order 20% up to $100 per prescription	**All Tiers + Specialty:** 40% up to $250 per prescription / mail order not covered

*After deductible | **Deductible amounts vary depending on IRS limits