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2027 Retiree Health Program Enrollment Selection Guide
Anthem Blue Cross Blue Shield Plan Highlights

Hospital/Medical	Under Age 65 or Non-Medicare Eligible		Over Age 65 or Under Age 65 And Medicare Eligible
	In Network	Out-of-Network	In Network
Annual Inpatient Hospital Deductible *	50% of Medicare Part A deductible	50% of Medicare Part A deductible	50% of Medicare Part A deductible
Annual Medical Deductible	$375 per person $1,025 per family	$900 per person $2,600 per family	$850 per person $2,450 per family
Annual Out-of-Pocket Max	$1,000 per person $2,800 per family	$3,500 per person	$3,450 per person
Inpatient Hospital / Skilled Nursing Facility Admission**	After hospital deductible, plan pays 100% of semi-private room and board up to 365 days per diagnosis	After hospital deductible, plan pays 70% of semi-private room and board up to 365 days per diagnosis	After hospital deductible, plan pays 100% of semi-private room and board up to 365 days per diagnosis
Emergency Room Visit	$150 copay; waived if admitted	$150 copay; waived if admitted	$150 copay; waived if admitted
Co-insurance	After in-network medical deductible, plan pays 90%	After out-of-network deductible, plan pays 70%	After medical deductible, plan pays 70%
Physician Office Visits / Specialist Office	$30 copay $40 copay	After annual medical deductible, plan pays 70%	After medical deductible, plan pays 70%
Routine Preventive Care and Immunizations***	Plan pays 100%, no copay	Not covered	Plan pays 100%, no copay
Routine Mammograms, PAP, PSA	Plan pays 100%, no copay	Plan pays 100%, no deductible	Plan pays 100%, no deductible
Outpatient Surgery	Plan pays 100%, no copay	Plan pays 100%, no deductible	After medical deductible, plan pays 100%
Vision (CPS Optical)	1 routine eye exam every 12 months; 1 pair of eyeglasses every 24 months	1 routine eye exam every 12 months; 1 pair of eyeglasses every 24 months	1 routine eye exam every 12 months; 1 pair of eyeglasses every 24 months****

** Retirees can have more than one benefit period in a calendar year*
*** Custodial care is not a covered health service*
**** Some vaccinations are covered (i.e. Shingles vaccination)*
***** No need to coordinate with Medicare*

Notes:
1) Plan payments for covered health services are based on usual and customary charges.
2) Should there be a conflict between this summary and the Plan Document, the Plan Document will be the final authority.
3) This chart provides a brief glimpse of some of your Benefits. For more in-depth details or to review the HMO plans, visit www.retirees.coned.com and see Benefit Summaries for each Plan.

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2027 Retiree Health Program Enrollment Selection Guide
CVS Health / SilverScript Prescription Drugs

CVS Health Plan Highlights Retirees Under Age 65 Or Non-Medicare Eligible			
Prescription	**Retail**	**Preferred Network and Mail 90 Day Supply**	
Annual Deductible	**$150 per person**	**None**	
Annual Out-Of-Pocket Maximum	**None**		
Copays	**Generic Drugs (A)**	**Preferred Brand Drugs (B)**	**Non-Preferred Brand Drugs (C)**
30-Day Supply (any network pharmacy*)	**$15**	**$40**	**$60**
90-Day Supply (Mail and Preferred Network Pharmacy)**	**$35**	**$100**	**$150**
GLP-1s for Weight Loss- Copays* **			
30-Day Supply (any network pharmacy*)	**$100**		
90-Day Supply (Mail and Preferred Network Pharmacy)**	**$300**		

SilverScript Plan Highlights Retirees Over 65 Or Under 65 And On Medicare			
Prescription	**Retail**	**Preferred Network and Mail 90 Day Supply**	
Annual Deductible	**$150 per person**	**None**	
Annual Out-Of-Pocket Maximum	**None**		
Copays	**Preferred Network Retail Pharmacy***	**Network Retail Pharmacy****	**Mail Order**
Generic Drugs	Active ingredients in generic drugs are exactly the same as active ingredients in brand drugs whose patents have expired. They are required by the FDA to be as safe and effective as the brand drug.		
30-Day Supply	**$15**	**$15**	**$35**
90-Day Supply	**$35**	**$45**	**$35**
Preferred Brand Drugs	Brand drugs that do not have a generic equivalent and are included on a preferred drug list.		
30-Day Supply	**$40**	**$40**	**$100**
90-Day Supply	**$100**	**$120**	**$100**
Non-Preferred Brand Drugs	Brand drugs that are not on a preferred drug list and usually are a higher cost.		
30-Day Supply	**$60**	**$60**	**$150**
90-Day Supply	**$150**	**$180**	**$150**
GLP-1 Coverage for Weight Loss* **			
30-Day Supply	**$100**	**$100**	**$300**
90-Day Supply	**$300**	**$300**	**$300**
Specialty Drugs	For information about your copays when you fill prescriptions for specialty drugs, please see the 2027 Summary of Benefits document located at http://conedcecony.silverscript.com.		

**The network includes CVS and it's affiliated pharmacies, which may offer you lower costs than other network pharmacies. If you use a preferred network pharmacy, the deductible will be waived if your script is for a 90-Day supply.*

***The plan has a network of pharmacies, including retail, mail-order, long-term care and home infusion pharmacies. To find a network pharmacy near you, call the Pharmacy Benefit Manager at the number listed on your prescription card.*

****The GLP-1 Copay does not apply if being prescribed for Diabetes, standard copays apply.*