## Proposed HMO Comparison

**Effective 1/1/2023 - 12/31/2023**

### General Plan Information

#### Individual/Individual in Family/Family

<table>
<thead>
<tr>
<th>Plan</th>
<th>ANTHEM BLUE CROSS</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO 10 IN-NETWORK ONLY</td>
<td>Annual Medical and Prescription Drug Combined Out-of-Pocket Limit</td>
<td>$1,500/$1,500/$4,500</td>
</tr>
<tr>
<td>HMO 30 IN-NETWORK ONLY</td>
<td>$1,500/$1,500/$3,000</td>
<td>$1,500/$1,500/$3,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
<th>ANTHEM BLUE CROSS</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO 10 IN-NETWORK ONLY</td>
<td>Annual Medical Deductible</td>
<td>Individual/Family</td>
</tr>
<tr>
<td>HMO 30 IN-NETWORK ONLY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
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<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO 10 IN-NETWORK ONLY</td>
<td>Physician/Diagnostic Services</td>
<td>Preventive Care</td>
</tr>
<tr>
<td>HMO 30 IN-NETWORK ONLY</td>
<td>TeleMedicine (Audio/Video Visits)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary Care Office Visit</td>
<td>$10 Copay</td>
</tr>
<tr>
<td></td>
<td>Specialist Office Visit</td>
<td>$10 Copay</td>
</tr>
<tr>
<td></td>
<td>Diagnostic X-Ray and Lab Tests</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Advanced Imaging</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>ANTHEM BLUE CROSS</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO 10 IN-NETWORK ONLY</td>
<td>Inpatient Hospitalization</td>
<td></td>
</tr>
<tr>
<td>HMO 30 IN-NETWORK ONLY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
<th>ANTHEM BLUE CROSS</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO 10 IN-NETWORK ONLY</td>
<td>Outpatient Services</td>
<td>Outpatient Surgery</td>
</tr>
<tr>
<td>HMO 30 IN-NETWORK ONLY</td>
<td></td>
<td>Outpatient Lab and Imaging</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
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</tr>
</thead>
<tbody>
<tr>
<td>HMO 10 IN-NETWORK ONLY</td>
<td>Emergency Services</td>
<td>Ambulance Services</td>
</tr>
<tr>
<td>HMO 30 IN-NETWORK ONLY</td>
<td></td>
<td>Emergency Room</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO 10 IN-NETWORK ONLY</td>
<td>Urgent Care</td>
<td>Urgent Care Visits</td>
</tr>
<tr>
<td>HMO 30 IN-NETWORK ONLY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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1The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to per person out-of-pocket maximum. In addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum.
## General Plan Information

<table>
<thead>
<tr>
<th>Mental Health and Substance Abuse</th>
<th>ANTHEM BLUE CROSS</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Mental Health</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Outpatient Mental Health Office Visit</td>
<td>$10 Copay</td>
<td>$0</td>
</tr>
<tr>
<td>Other Outpatient Mental Health Services</td>
<td>$0</td>
<td>$30 Copay</td>
</tr>
</tbody>
</table>

### Prescription Drug Benefits

<table>
<thead>
<tr>
<th>Prescription Drug Formulary (Covered Drugs)</th>
<th>ANTHEM BLUE CROSS</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formulary (Covered Drugs)</td>
<td>National 3-Tier</td>
<td>National 4-Tier</td>
</tr>
<tr>
<td>Retail</td>
<td>30-Day Supply</td>
<td>30-Day Supply</td>
</tr>
<tr>
<td>Generic</td>
<td>$10 Copay</td>
<td>$15 Copay</td>
</tr>
<tr>
<td>Brand (Formulary/Preferred)</td>
<td>$20 Copay</td>
<td>$30 Copay</td>
</tr>
<tr>
<td>Brand (Non-Formulary/Non-Preferred)</td>
<td>$20 Copay</td>
<td>$50 Copay</td>
</tr>
<tr>
<td>Specialty Rx (Specialty Pharmacy Only; 30-day supply)</td>
<td>$20 Copay</td>
<td>30% Coinsurance (Not to Exceed $150)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail Order</th>
<th>90-Day Supply</th>
<th>90-Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$20 Copay</td>
<td>$15 Copay</td>
</tr>
<tr>
<td>Brand (Formulary/Preferred)</td>
<td>$40 Copay</td>
<td>$60 Copay</td>
</tr>
<tr>
<td>Brand (Non-Formulary/Non-Preferred)</td>
<td>$40 Copay</td>
<td>$100 Copay</td>
</tr>
<tr>
<td>Specialty Rx (Specialty Pharmacy Only; 30-day supply)</td>
<td>$40 Copay</td>
<td>30% Coinsurance (Not to Exceed $300)</td>
</tr>
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<th>Mail Order</th>
<th>100-Day Supply</th>
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<tr>
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Note: This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the EOC, the EOC will prevail.