

CARRIER	ANTHEM BLUE CROSS							KAISER PERMANENTE
PLAN NAME	PPO 90		PPO 80		CDHP 90		CDHP	
GENERAL PLAN INFORMATION	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK ONLY	
Annual Medical Out-of-Pocket Limit								
Individual/Individual in Family/Family	\$2,000/\$2,000/\$6,000 ²	Unlimited	\$3,000/\$3,000/\$9,000 ²	Unlimited	\$3,000/\$6,000/\$6,000 (Combined Medical & Rx Out-of-Pocket Max)	Unlimited	\$3,200/\$3,200/\$6,400 ³ (Combined Medical & Rx Out-of-Pocket Max)	
Annual Medical Deductible - Plan Deductible Applies Unless Otherwise Stated								
Individual/Family	\$500/\$500/\$1,500 ²	\$1,000/\$1,000/\$3,000 ²	\$750/\$750/\$2,250 ²	\$1,500/\$1,500/\$4,500 ²	\$1,600/\$3,200/\$3,200 (Combined Medical & Rx Deductible)	\$4,000/\$8,000/\$8,000 (Combined Medical & Rx Deductible)	\$1,600/\$3,200/\$3,200 (Combined Medical & Rx Deductible)	
Plan Information								
Type of Plan	Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Health Maintenance Organization (HMO)	
Referrals Required?	No		No		No		Yes	
Plan Coinsurance	Plan Pays 90% (After Deductible)	50% Coinsurance (After Deductible)	Plan Pays 80% (After Deductible)	50% Coinsurance (After Deductible)	Plan Pays 90% (After Deductible)	50% Coinsurance (After Deductible)	Plan Pays 90% (After Deductible)	
Health Savings Account (HSA) Compatibility:								
HSA-Compatible Plan?	No		No		Yes		Yes	
2024 Individual Maximum Contribution	N/A		N/A		\$4,150		\$4,150	
2024 Family Maximum Contribution	N/A		N/A		\$8,300		\$8,300	
Over 55 HSA Contribution Catch-Up	N/A		N/A		\$1,000		\$1,000	
Physician/Diagnostic Services								
Preventive Care	\$0 (Deductible Waived)	Not Covered	\$0 (Deductible Waived)	Not Covered	\$0 (Deductible Waived)	Not Covered	\$0	
Primary Care Office Visit	\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	
Specialist Office Visit	\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	
Diagnostic X-Ray and Lab Tests	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	
Advanced Imaging (MRI/PET/CAT Scans)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$800 per procedure maximum	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$800 per procedure maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$800 per procedure maximum	10% Coinsurance (After Deductible)	
Inpatient Hospital Services								
Inpatient Hospitalization	10% ⁴ Coinsurance (After Deductible)	50% ⁴ Coinsurance (After Deductible) up to \$1,000 maximum per day	20% ⁴ Coinsurance (After Deductible)	50% ⁴ Coinsurance (After Deductible) up to \$1,000 maximum per day	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 maximum per day	10% Coinsurance (After Deductible)	
Outpatient Services								
Outpatient Surgery	10% ⁴ Coinsurance (After Deductible)	50% ⁴ Coinsurance (After Deductible) up to \$350 per day maximum	20% ⁴ Coinsurance (After Deductible)	50% ⁴ Coinsurance (After Deductible) up to \$350 per day maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$350 per day maximum	10% Coinsurance (After Deductible)	
Outpatient Lab and Imaging	10% ⁴ Coinsurance (After Deductible)	50% ⁴ Coinsurance (After Deductible) up to \$350 per procedure maximum	20% ⁴ Coinsurance (After Deductible)	50% ⁴ Coinsurance (After Deductible) up to \$350 per procedure maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$350 per procedure maximum	10% Coinsurance (After Deductible)	
Emergency Services								
Ambulance Services	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)	
Emergency Room	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)	
Urgent Care								
Urgent Care Visits	\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	

¹When using out-of-network providers, you are responsible for the deductible, coinsurance, and additional amounts exceeding the usual and customary charges.

²The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

³The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum. In addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum.

⁴\$250 deductible applies if utilization review is not obtained (waived for emergency admissions and outpatient freestanding surgery centers).

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Mental Health and Substance Abuse								
Inpatient Mental Health	10% ⁴ Coinsurance (After Deductible)	50% ⁴ Coinsurance (After Deductible) up to \$1,000 per day maximum	20% ⁴ Coinsurance (After Deductible)	50% ⁴ Coinsurance (After Deductible) up to \$1,000 per day maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 per day maximum	10% Coinsurance (After Deductible)	
Outpatient Mental Health Office Visit	\$10 copay	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	
Other Outpatient Mental Health Services	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	
Other Services								
Acupuncture	10% Coinsurance (After Deductible)	Not Covered	20% Coinsurance (After Deductible)	Not Covered	10% Coinsurance (After Deductible), maximum of 20 visits per calendar year, then plan pays 0%	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	No Coverage	
Chiropractor Services	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	10% Coinsurance (After Deductible), maximum of 30 visits per calendar year, then plan pays 0%	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	No Coverage	
Hearing Aids	\$500 Maximum Benefit per Ear, Every 12 Months		\$500 Maximum Benefit per Ear, Every 12 Months		\$500 Maximum Benefit per Ear, Every 12 Months		No Coverage	
Fertility Benefits	WINFertility, Two-Cycle Benefit for Medical, \$20K Rx Lifetime Maximum, \$10K Lifetime Maximum Adoption		WINFertility, Two-Cycle Benefit for Medical, \$20K Rx Lifetime Maximum, \$10K Lifetime Maximum Adoption		WINFertility, Two-Cycle Benefit for Medical, \$20K Rx Lifetime Maximum, \$10K Lifetime Maximum Adoption		No Coverage	
PRESCRIPTION DRUG BENEFITS								
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY	
Annual Prescription Drug Out-of-Pocket Limit								
Individual/Individual in Family/Family	\$2,000/\$2,000/\$4,000 ²	Unlimited	\$2,000/\$2,000/\$4,000 ²	Unlimited	Combined with Medical	Unlimited	Combined with Medical	
Annual Prescription Drug Deductible								
Per Individual	\$0		\$0		Combined with Medical		Combined with Medical	
Prescription Drug Formulary								
Formulary (Covered Drugs)	National 3-Tier		National 3-Tier		National 4-Tier		CA Commercial 3-Tier	
Retail								
	30-Day Supply		30 days		30 days		30 days	
Generic	\$5 min Copay/ or 20% up to a \$25 Max Copay (Deductible Waived)	Paper claim submission required	\$10 Copay (Deductible Waived)	Paper claim submission required	\$10 Copay (After Deductible)	Paper claim submission required	\$10 Copay (After Deductible)	
Brand (Formulary/Preferred)			\$20 Copay (Deductible Waived)		\$30 Copay (After Deductible)		\$30 Copay (After Deductible)	
Brand (Non-Formulary/Non-Preferred)			\$35 Copay (Deductible Waived)		\$30 Copay (After Deductible)		\$30 Copay (After Deductible)	
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	Same as Retail Brand	Same as Retail Brand	Same as Retail Brand	Same as Retail Brand	20% Coinsurance (After Deductible; Not to Exceed \$150)	20% Coinsurance (After Deductible; Not to Exceed \$150)	20% Coinsurance (After Deductible; Not to Exceed \$150)	
Mail Order								
	90-Day Supply		90-Day Supply		90-Day Supply		100-Day Supply	
Generic	\$5 Copay (Deductible Waived)	Paper claim submission required	\$20 Copay (Deductible Waived)	Paper claim submission required	\$20 Copay (After Deductible)	Paper claim submission required	\$20 Copay (After Deductible)	
Brand (Formulary/Preferred)			\$40 Copay (Deductible Waived)		\$60 Copay (After Deductible)		\$60 Copay (After Deductible)	
Brand (Non-Formulary/Non-Preferred)			\$70 Copay (Deductible Waived)		\$60 Copay (After Deductible)		\$60 Copay (After Deductible)	
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	Same as Retail Brand	Same as Retail Brand	\$70 Copay (Deductible Waived)	Same as Retail Brand	20% Coinsurance (After Deductible; Not to Exceed \$150)	20% Coinsurance (After Deductible; Not to Exceed \$150)	20% Coinsurance (After Deductible; Not to Exceed \$150)	

¹For Anthem PPO 90 & 80: The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

²\$250 deductible applies if utilization review is not obtained (waived for emergency admissions and outpatient freestanding surgery centers).

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 Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.