



PLAN NUMBER	ANTHEM BLUE CROSS		KAISER PERMANENTE	
	SELECT HMO 10	SELECT HMO 30	HMO 10	HMO 30
GENERAL PLAN INFORMATION	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK ONLY
Annual Medical and Prescription Drug Combined Out-of-Pocket Limit¹				
Individual/Individual in Family/Family	\$1,500/\$1,500/\$4,500	\$5,000/\$5,000/\$10,000	\$1,500/\$1,500/\$3,000	\$1,500/\$1,500/\$3,000
Annual Medical Deductible				
Individual/Family	\$0	\$0	\$0	\$0
Physician/Diagnostic Services				
Preventive Care	\$0	\$0	\$0	\$0
TeleMedicine (Audio/Video Visits)	\$0	\$0	\$0	\$0
Primary Care Office Visit	\$10 Copay	\$30 Copay	\$10 Copay	\$30 Copay
Specialist Office Visit	\$10 Copay	\$40 Copay	\$10 Copay	\$30 Copay
Diagnostic X-Ray and Lab Tests	\$0	\$0	\$0	\$0
Advanced Imaging	\$0	\$100 Copay per Test	\$0	\$0
Inpatient Hospital Services				
Inpatient Hospitalization	\$0	30% Coinsurance	\$0	\$0
Outpatient Services				
Outpatient Surgery	\$0	30% Coinsurance	\$10 Copay per Procedure	\$30 Copay per Procedure
Outpatient Lab and Imaging	\$0	30% Coinsurance	\$0	\$0
Emergency Services				
Ambulance Services	\$0	\$100 per trip	\$50 per trip	\$50 per trip
Emergency Room	\$50 Copay (Waived if Admitted)	\$200 Copay (Waived if Admitted)	\$50 Copay (Waived if Admitted)	\$50 Copay (Waived if Admitted)
Urgent Care				
Urgent Care Visits	\$10 Copay	\$30 Copay	\$10 Copay	\$30 Copay

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.





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	SELECT HMO 10	SELECT HMO 30	HMO 10	HMO 30
GENERAL PLAN INFORMATION	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK ONLY
Mental Health and Substance Abuse				
Inpatient Mental Health	\$0	30% Coinsurance	\$0	\$0
Outpatient Mental Health Office Visit	\$10 Copay	\$30 Copay	\$10 Copay	\$30 Copay
Other Outpatient Mental Health Services	\$0	30% Coinsurance	\$0	\$0
Other Services				
Hearing Aids	1 per Ear, Every 36 Months	\$2,500 Maximum Benefit per Ear, Every 36 Months	\$2,500 Maximum Benefit per Ear, Every 36 Months	\$2,500 Maximum Benefit per Ear, Every 36 Months
Infertility Diagnosis & Treatment	3-Cycle, Unlimited Rx	3-Cycle, Unlimited Rx	3-Cycle, Unlimited Rx	3-Cycle, Unlimited Rx
PRESCRIPTION DRUG BENEFITS				
Annual Prescription Drug Out-of-Pocket Limit				
Individual/Individual in Family/Family	Combined with Medical	Combined with Medical	Combined with Medical	Combined with Medical
Prescription Drug Deductible				
Per Individual	\$0	\$0	\$0	\$0
Prescription Drug Formulary				
Formulary (Covered Drugs)	National 3-Tier	National 4-Tier	CA Commercial 2-Tier	CA Commercial 3-Tier
Retail				
	30-Day Supply	30-Day Supply	30-Day Supply	30-Day Supply
Generic	\$10 Copay	\$15 Copay	\$10 Copay	\$15 Copay
Brand (Formulary/Preferred)	\$20 Copay	\$30 Copay	\$20 Copay	\$30 Copay
Brand (Non-Formulary/Non-Preferred)	\$20 Copay	\$50 Copay	\$20 Copay	\$30 Copay
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	\$20 Copay	30% Coinsurance (Not to Exceed \$150)	\$20 Copay	50% Coinsurance (Not to Exceed \$200)
Mail Order				
	90-Day Supply	90-Day Supply	100-Day Supply	100-Day Supply
Generic	\$20 Copay	\$15 Copay	\$10 Copay	\$30 Copay
Brand (Formulary/Preferred)	\$40 Copay	\$60 Copay	\$20 Copay	\$60 Copay
Brand (Non-Formulary/Non-Preferred)	\$40 Copay	\$100 Copay	\$20 Copay	\$60 Copay
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	\$40 Copay	30% Coinsurance (Not to Exceed \$300)	Retail Only	Retail Only

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.

