



2023-2024	Kaiser	Anthem	Anthem	Anthem
	Trad HMO \$15	Premier 10	90-G \$20	80-G \$20
MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	\$0	\$0/\$0	\$500/\$1,000	\$500/\$1,000
Individual/Family Out-of-Pocket (OOP) Max <i>(includes medical deductibles, co-insurance and co-pays)</i>	\$1,500/\$3,000	\$1,000/\$2,000	\$1,000/\$3,000	\$2,000/\$4,000

PROFESSIONAL SERVICES

Office Visit (OV) co-pay <i>(\$0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)</i>	\$15	\$10	\$20	\$20
Urgent Care co-pay	\$15	\$10	\$20	\$20
Specialists/Consultants co-pay	\$15	\$10	\$20	\$20
Prenatal, postnatal office visit co-pay	\$0	\$10	\$20	\$20
Scans: CT, CAT, MRI, PET etc.	\$0	\$100/test	10%	20%
Diagnostic X-ray & Laboratory Procedures	\$0	\$0	10%	20%
Infertility (Refer to Plan Document)	Co-pay applies	50%	Not covered	Not covered
Preventive Care (includes physical exams & screenings)	\$0	\$0	0% Ded Waived	0% Ded Waived

HOSPITAL & SKILLED NURSING FACILITY SERVICES

Emergency Room visit (copay waived if admitted)	\$100	\$100	10% \$100 co-pay	20% \$100 co-pay
Inpatient Hospital (preauthorization required) - limits may apply	\$0	\$0	10%	20%
Outpatient Hospital	\$15	\$0	10%	20%
Surgery, Outpatient (performed in Surgery Center)	\$15	\$0	10%	20%
Surgery, Outpatient (performed in a Hospital) - limits may apply	\$15	\$0	10%	20%

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

INPATIENT: Facility Based Care (preauth required)	\$0	\$0	10%	20%
OUTPATIENT: Facility Based Care (preauth required)	\$15	\$0	10%	20%

OTHER SERVICES

Ambulance (Ground or Air)	\$50	\$100	10% \$100 co-pay	20% \$100 co-pay
Acupuncture - Limits apply	\$10/30 visits (through ASH) combined w/chiro	\$10/30 visits combined w/chiro	10% Uses ASH Network	20% Uses ASH Network
Chiropractic - Limits apply	\$10/30 visits (through ASH) combined w/acu	\$10/30 visits combined w/acu	10% Uses ASH Network	20% Uses ASH Network
Durable Medical Equipment (DME)	no charge	0%	10%	20%
Physical and Occupational Therapy - Limits apply	\$15	\$10	10%	20%
Hearing Aids	amount in excess of \$500 allowance every 36 months	50% Coinsurance 1 device per ear/36 months	10% and Amount in excess of \$700 allowance/24 months	20% and Amount in excess of \$700 allowance/24 months

PHARMACY BENEFITS

Plan	Custom \$5-\$20 (30 day)	5-20	5-20	5-20
Pharmacy Benefit Manager	Kaiser	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none
Individual/Family Rx Out-of-Pocket (OOP) Max <i>(includes Rx deductibles and co-pays)</i>	Included w/ Med OOP Max	\$1,500/\$2,500	\$1,500/\$2,500	\$1,500/\$2,500
Generic co-pay/30 days supply	\$5 up to 30 day supply	\$0 at Costco \$5 at Other Network	\$0 at Costco \$5 at Other Network	\$0 at Costco \$5 at Other Network
Brand co-pay/30 days supply	\$20 up to 30 day supply	\$20.00	\$20.00	\$20.00
Specialty co-pay/up to 30 days supply	\$20 up to 30 day supply	\$20 Must Use Navitus Mail	\$20 Must Use Navitus Mail	\$20 Must Use Navitus Mail
Mail Order (Generic-Brand co-pay/90 days supply)	\$10-\$40/up to 100 day supply	\$0-\$50	\$0-\$50	\$0-\$50
Mail Order Pharmacy	Kaiser Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy

This sheet is only a brief summary of In-Network patient costs. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Out-of-Network services may not be covered. Employee cost/payroll deduction, if applicable, can be requested from the district.