

Plan	Anthem BCBS PPO 80/60		Anthem BCBS EPO 90	Kaiser EPO High	Kaiser EPO 80
	Network	Out-of-Network	Network Only	Network Only	Network Only
Annual Medical Deductible	\$500 per person \$1,000 per family	\$1,000 per person \$2,000 per family	\$200 per person \$500 per family	\$0 per person \$0 per family	\$500 per person \$1,000 per family
Annual Out-of-Pocket Maximum	\$2,500 per person \$5,000 per family	\$6,500 per person \$13,000 per family	\$1,700 per person \$3,500 per family	\$1,750 per person \$3,500 per family	\$3,500 per person \$7,000 per family
Preventive Care					
Preventive Services & Well-Child Care	\$0 copay	40% coinsurance	\$0 copay	\$0 copay (Frequency and age limits for those age 24 months and older are managed by the KP provider. Well-child check-ups are limited to those less than 24 months old.)	\$0 copay (Frequency and age limits for those age 24 months and older are managed by the KP provider. Well-child check-ups are limited to those less than 24 months old.)
Physician Services					
Office Visit	\$25 copay	40% coinsurance	\$25 copay	\$25 copay	\$25 copay
Diagnostic Services	20% coinsurance	20% coinsurance	20% coinsurance	\$50 copay	20% coinsurance
Specialist Care	\$25 copay	40% coinsurance	\$25 copay	\$25 copay	\$35 copay
Hospital Services					
Inpatient Services (including inpatient maternity services)	Copay of \$100 per day not to exceed \$600, then 20% coinsurance	40% coinsurance	10% coinsurance	\$100 per day copay to maximum of \$600	20% coinsurance
Outpatient Surgery	20% coinsurance	40% coinsurance	10% coinsurance	\$100 copay	20% coinsurance
Emergency Room Care	\$100 copay	\$100 copay	\$100 copay	\$100 copay	20% coinsurance
Ambulance Services	20% coinsurance	20% coinsurance	10% coinsurance	\$0 copay	20% coinsurance

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.

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Mental Health/Substance Abuse					
Outpatient Services	\$20 copay Services are provided through Cigna Behavioral Health, not through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	Network - \$20 copay Out-of-Network - 30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	\$25 copay per visit for individual visit; \$10 for group visit	\$25 copay per visit for individual visit; \$12 for group visit
Inpatient Services	Covered at 100% after \$100 per day copay/\$600 maximum Services are provided through Cigna Behavioral Health, not through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	Network - 10% coinsurance Out-of-Network - 30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	\$100 per day copay to maximum of \$600	20% coinsurance
Other Medical Services					
Durable Medical Equipment	20% coinsurance	20% coinsurance	10% coinsurance	\$0 copay	20% coinsurance
Home Health Care	20% coinsurance	40% coinsurance	10% coinsurance	\$0 copay	\$0 copay

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Outpatient Therapy	\$25 copay (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	40% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	\$25 copay (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	\$25 copay (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	\$25 copay (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)
Skilled Nursing / Acute Rehabilitation Facility	20% coinsurance	40% coinsurance	10% coinsurance	\$0 copay	20% coinsurance
Urgent Care Services	20% coinsurance	40% coinsurance	10% coinsurance	\$50 copay	\$50 copay