



**KCCD - Plan Comparison
Effective October 1, 2017**

Effective October 1, 2017	Anthem PPO	Anthem PPO	Anthem PPO	Kaiser HMO*
	100-A \$20	90-G \$20	80-G \$30	Trad HMO \$10
MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	\$0/\$0	\$500/ \$1,000	\$500/ \$1,000	\$0, no deductible
Individual/Family Out-of-Pocket (OOP) Max <i>(includes medical deductibles, co-insurance and co-pays)</i>	\$1,000/ \$3,000	\$1,000/ \$3,000	\$2,000/ \$4,000	\$1,500/ \$3,000

PROFESSIONAL SERVICES

Office Visit (OV), Urgent Care or Specialist/Consultants co-pay	\$20	\$20	\$30	\$10
Prenatal, postnatal office visit co-pay	\$20	\$20	\$30	\$0, no charge
Scans: CT, CAT, MRI, PET etc.	0%	10%	20%	\$0, no charge
Diagnostic X-ray & Laboratory Procedures	0%	10%	20%	\$0, no charge
Infertility (diagnosis/treatment of causes of infertility)	Not covered	Not covered	Not covered	\$10 OV, no charge hospital
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived	\$0, no charge

HOSPITAL & SKILLED NURSING FACILITY SERVICES

Emergency Room visit (waived if admitted)	0% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	\$100
Inpatient Hospital (preauthorization required)	0%	10%	20%	\$0, no charge
Outpatient Hospital	0%	10%	20%	\$10
Surgery, Outpatient (performed in Surgery Center)	0%	10%	20%	\$10
Surgery, Outpatient (performed in a Hospital)	0%	10%	20%	\$10

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

INPATIENT: Facility Based Care (preauth required)	0%	10%	20%	\$0, no charge
OUTPATIENT: Facility Based Care (preauth required)	0%	10%	20%	\$10

OTHER SERVICES

Acupuncture or Chiropractic - Limits apply	0%	10%	20%	\$10/30 visits combined
Ambulance (Ground or Air)	0% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	\$50
Durable Medical Equipment (DME)	0%	10%	20%	\$0, no charge
Physical and Occupational Therapy - Limits apply	0%	10%	20%	\$10

PHARMACY BENEFITS

Plan	5-20	7-25	7-25	Trad HMO \$10
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	\$1,500/ \$2,500	\$1,500/ \$2,500	\$1,500/ \$2,500	Included w/ Med OOP Max
Generic co-pay/30 days supply	\$0 at Costco \$5 at Other Network	\$0 at Costco \$7 at Other Network	\$0 at Costco \$7 at Other Network	\$10 up to 100 day supply
Brand co-pay/30 days supply	\$20	\$25	\$25	\$10 up to 100 day supply
Specialty co-pay/up to 30 days supply	\$20 Must Use Navitus Mail	\$25 Must Use Navitus Mail	\$25 Must Use Navitus Mail	\$10 up to 100 day supply
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$50	\$0-\$60	\$0-\$60	\$10-\$10/up to 100 day supply

This is simply a Plan Election Form with a brief overview of benefits. For details, limitations and exclusions please refer to the Benefit Summary or Plan Booklet.

* You must live or work in a Kaiser service area to be eligible to enroll.