# ANTHEM PPO PLANS

The Plans At-a-Glance are intended to provide a general overview. For specific information, see Summary of Benefits & Coverages (SBCs).

| | PPO – Prudent Buyer | | PPO HDHP/HSA Prudent Buyer | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Annual Deductible** | Individual: $200<br>Family: $400 | Individual: $400<br>Family: $800 | Individual: $1.600<br>Member: $3,200<br>Family: $4,000<br>**Subject to change every year on January 1 | Individual: $4.500<br>Member: $4,500<br>Family: $9,000<br>**Subject to change every year on January 1 |
| **Annual Out-of-Pocket Maximum** | Individual: $2,000<br>Family: $4,000 | Individual: $4,000<br>Family: $8,000<br>*Could be unlimited due to balance billing with Out-of-Network providers. | Individual: $4,000<br>Member:$4,000<br>Family: $8,000<br>**Subject to change every year on January 1 | Individual: $9,000<br>Member: $9,000<br>Family: $18,000<br>*Could be unlimited due to balance billing with Out-of-Network providers.<br>**Subject to change every year on January 1 |
| **Office Visit** | $10 copay<br>$10 copay for specialist | 40%*<br>40%for specialist* | 20%<br>20% for specialist | 40%* |
| **Online Visit** | $10 copay | 40%* | 20% | 40%* |
| **Chiropractic** | 20% | 40%* | 20% | 40%* |
| **Lab and X-ray** | 20% | 40%* | 20% | 40%* |
| **Urgent Care** | $10 copay | 40%* | 20% | 40%* |
| **Emergency Room** | $100 copay/visit + 20%<br>($100 waived if admitted) | Covered as In-Network | 20% | Covered as In-Network |
| **Hospitalization** | 20% | 40%* | 20% | 40%* |
| **Outpatient Surgery** | No charge | 40%* | 20% | 40%* |
| **PRESCRIPTION DRUGS** | | | | |
| **Deductible** | None | None | Combined with In-Network medical out-of-pocket limit | Combined with Non-Network medical out-of-pocket limit |
| **Out-of-Pocket Maximum** | Combined with In-Network medical out-of-pocket limit | Combined with Non-Network medical out-of-pocket limit | Combined with In-Network medical out-of-pocket limit | Combined with Non-Network medical out-of-pocket limit |
| **Generic** | $10 copay (retail and home delivery) | 50% up to $250 per prescription (retail). Not covered (home delivery) | **Lowest cost generic** $5 copay. (retail) and $10 copay (home delivery). **Generic** $15 copay (retail) and $30 (home delivery) | 40% up to $250 per prescription (retail). Not covered (home delivery) |
| **Brand Name** | **Preferred**: $20 (retail and home delivery)<br>**Non-Preferred:** $20 (retail and home delivery) | 50% up to $250 per prescription (retail). Not covered (home delivery) | **Preferred**: $40 copay (retail) and $100 copay (home delivery)<br>**Non-Preferred**:$60 copay (retail) and $150 copay (home delivery) | 40% up to $250 per prescription (retail). Not covered (home delivery) |
| **Specialty** | $20 copay (retail and home delivery) | Not covered (retail and home delivery) | 30% up to $250 (retail and home delivery) | 40% up to $250 per prescription (retail). Not covered (home delivery) |
| **Supply Limits** | Retail – 30 day<br>Home delivery - 90 day | Retail – 30 day<br>Home delivery - 90 day | Retail – 30 day<br>Home delivery - 90 day | Retail – 30 day<br>Home delivery - 90 day |

# ANTHEM AND KAISER HMO PLANS

| | Anthem HMO Plan | Kaiser Traditional HMO Plan | Kaiser Deductible HMO Plan |
|---|---|---|---|
| | In-Network | In-Network | In-Network |
| Annual Deductible | Individual: $0<br>Family: $0 | Individual: $0<br>Family: $0 | Individual: $1.000<br>Family: $2,000 |
| Annual Out-of-Pocket Maximum | Individual: $500<br>Family: $1,500 | Individual: $1,500<br>Family: $3,000 | Individual: $3,000<br>Family: $6,000 |
| Office Visit | $10 copay<br>$10 copay for specialist | $10 copay<br>$10 copay for specialist | $20 copay<br>$20 copay for specialist |
| Online Visit | $10 copay | No charge | No charge |
| Chiropractic | No charge | $10 copay (30 visits) | $10 copay (30 visits) |
| Lab and X-ray | No charge | No charge | $10 copay |
| Urgent Care | $10 copay | $10 copay | $20 copay |
| Emergency Room | $25 copay (copay waived if admitted) | $50 copay (copy waived if admitted) | 20% after plan deductible |
| Hospitalization | No charge | No charge | 20% after plan deductible |
| Outpatient Surgery | No charge | $10 copay | 20% after plan deductible |
| PRESCRIPTION DRUGS | | | |
| Deductible | None | None | None |
| Out-of-Pocket Maximum | Combined with In-Network medical out-of-pocket limit | None | None |
| Generic | $5 copay (retail 30-day supply) and home delivery 90-day supply) | $5 copay (retail and home delivery 100-day supply) | $10 copay (retail 30-day supply)<br>$20 copay (home delivery 100-day supply) |
| Brand Name | **Preferred:** $10 copay (retail 30-day supply and home delivery 90-day supply)<br>**Non-Preferred**:$10 copay (retail 30-day supply and home delivery 90-day supply) | $10 copay (retail and home delivery 100-day supply) | $30 copay (retail 30-day supply)<br>$60 copay ( home delivery 100-day supply) |
| Specialty brand and generic | $10 copay (retail 30-day supply and home delivery 90-day supply) | $10 copay (retail 30-day supply) | $30 copay (retail 30-day supply) |

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# DENTAL

**Does not include Hourly ACA-eligible.**

| | Guardian MDC-G90 DMO Managed Dental Care Option 1 | Guardian Buy-Up PPO Option 2 | | Guardian High Option PPO (Only available if enrolled in Anthem Blue Cross Prudent Buyer PPO Medical Plan or waived medical coverage. Option 3 | |
|---|---|---|---|---|---|
| | In-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Annual Deductible** | None | $50 (waived for preventive) | $50 | $50 (waived for preventive) | $50 (waived for preventive) |
| **Annual Plan Maximum** | N/A | $1000 | $1000 | $1,500 | $1000 |
| **Diagnostic & Preventive** | $0 | 80% | 80% | 100% | 100% |
| **Basic Services** | $0 - $95 | 80% | 60% | 90% | 80% |
| ○ Fillings | $0 | 80% | 60% | 90% | 80% |
| ○ Extractions | $0 -$40 | 80% | 60% | 90% | 80% |
| ○ Root Canal | $0 - $90 | 80% | 60% | 90% | 80% |
| **Major Services** | $90 - $130 | 50% | 40% | 60% | 50% |
| ○ Bridges and Dentures | $110 - $130 | 50% | 40% | 60% | 50% |
| ○ Crowns | $90 | 50% | 40% | 60% | 50% |
| **Orthodontia** | Children: $1,975 Adults $2,175 | Not covered | Not covered | Children: 60% $1,500 Lifetime max | Children: 50% $1,500 Lifetime max |

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# VISION

**Does not include Hourly ACA Eligible, GFFA or GPOA**

| | VSP Vision In-Network | Copay | Frequency |
|---|---|---|---|
| **Well Vision Exam** | Focuses on your eyes and overall wellness | $10 Exam and glasses | Every 12 months |
| **Frame*** | $170 featured frame brands allowance<br>$150 frame allowance<br>20% savings on the amount over your allowance<br>$80 Costco frame allowance | Combined with exam | Every 12 months |
| **Lenses** | Single-vision, lined bifocal, and lined trifocal lenses<br>Impact-resistant lenses for dependent children | Combined with exam | Every 12 months |
| **Lens Enhancements** | Standard progressive lenses<br><br>Tints/Light-reactive lenses<br><br>Premium progressive lenses<br><br>Custom progressive lenses<br>Average savings of 30% on other lens enhancements | $0<br><br>$0<br><br>$95 - $105<br><br>$150 - $175 | Every 12 months |
| **Contacts (Instead of glasses)** | $130 allowance for contacts and contact lens exam (fitting and evaluation) 15% savings on a contact lens exam (fitting and evaluation) | $0 | Every 12 months |
| **Lightcare*** | $150 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses instead of prescription glasses or contacts | Combined with exam | Every 12 months |

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.