Effective October 1, 2023

PLAN NAME	Kaiser HMO (SISC) $10 Copay	Anthem PPO (SISC) Plan 100-A $10, Rx $5/20	Anthem PPO (SISC) Plan 80-E $20, Rx $5/20
Individual/Family Deductibles	$0 / $0	$0 / $0	$300 / $600
Individual/Family Calendar Out-of-Pocket Max *(includes medical co-pays, deductibles and co-insurance)*	$1,500 / $3,000	$1,000 / $3,000	$1,000 / $3,000
PROFESSIONAL SERVICES			
Office Visit co-pay	$10	$10 (waived for visits 1-3)	$20 (waived for visits 1-3; ded waived)
Urgent Care co-pay	$10	$10	$20 (ded waived)
Specialists/Consultants co-pay	$10	$10	$20 (ded waived)
Prenatal, postnatal office visit co-pay	$0	$10	$20 (ded waived)
Scans: CT, CAT, MRI, PET etc.	$0	$0	20%
Diagnostic X-ray & Laboratory Procedures	$0	$0	20%
Infertility (diagnosis/treatment of causes of infertility)	Covered [1]	Covered - restrictions may apply	Covered - restrictions may apply
Preventive Care Services (includes physical exams & screenings)	$0	$0	$0 (ded waived)
HOSPITAL & SKILLED NURSING FACILITY SERVICES			
Emergency Room visit co-pay (waived if admitted)	$100	$100	$100 + 20%
Inpatient Hospital co-pay	$0	0%	20%
Outpatient Hospital co-pay	$10	0% - benefit limits may apply	20% - benefit limits may apply
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	$10	0%	20%
Surgery, Outpatient (performed in a Hospital)	$10	0% - benefit limits may apply	20% - benefit limits may apply
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT			
INPATIENT CARE: Facility based care (preauthorization required)	$0	0%	20%
OUTPATIENT CARE: Facility based care (preauthorization required)	Ind: $10 | Group: $5	0%	20%
OTHER SERVICES			
Acupuncture - Limits apply	$10 (30 visits/year, combined)	0% (12 visits/year)	20% (12 visits/year)
Ambulance (Ground or Air)	$50	$100	$100 + 20%
Chiropractic - Limits apply	$10 (30 visits/year, combined)	0% - pre-auth. after 5th visit	20% - pre-auth. after 5th visit
Durable Medical Equipment (DME)	$0	$0	20%
Physical and Occupational Therapy - Limits apply	$10	$0	20%
Vision Allowance	$150	Enrolled in UHC Vision	Enrolled in UHC Vision
Vision Exam	$0	Enrolled in UHC Vision	Enrolled in UHC Vision

PRESCRIPTION DRUG PLANS

Provider Network	Kaiser	Navitus	Navitus
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	Included w/ Med OOP Max	$1,500 / $2,500	$1,500 / $2,500
Tier/Generic 1 co-pay/days supply	$10 (100-day supply)	$5 (30-day supply)	$5 (30-day supply)
Tier 2/Brand co-pay/days supply	$10 (100-day supply)	$20 (30-day supply)	$20 (30-day supply)
Mail Order (Generic-Brand co-pay/days supply)	$10 / $10 (100-day supply)	$0 / $50 (90-day supply)	$0 / $50 (90-day supply)

[1] The Cost Share you would pay if the Services were to treat any other condition

Note: This is a brief benefit summary that reflects in-network benefits from a participating or contracted provider. For additional details, limitations, exclusions and out-of-network coverage, please refer to the Summary of Benefits or Coverage Booklet.