2024 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser HDHP
Member Services	1-866-641-1689	1-866-641-1689	1-866-641-1689	1-866-641-1689	1-866-641-1689	1-800-464-4000	1-800-464-4000
Website	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.kp.org/llns	www.kp.org/llns
HSA Funding	N/A	N/A	$750 Individual; $1,500 Family	N/A	$750 Individual; $1,500 Family	N/A	$750 Individual; $1,500 Family
Annual Deductible: Individual/Family	In Network - $300 Individual; $900 Family	In Network - $500 Individual; $1,500 Family	$3,000 Individual; $6,000 Family; combined in/out-of-network; no coverage paid for any member of a family unless $3,000 deductible is met	$0 Individual; $0 Family	In Network - $1,600 Individual; $3,200 Family; no coverage paid for any member of a family unless $3,200 deductible is met	$0 Individual; $0 Family	$1,600 Individual; $3,200 family (in total)
	Out of Network - $500 Individual; $1,500 Family	Out of Network - $1,000 Individual; $3,000 Family		No coverage Out-of-Network	Out of Network - $3,000 Individual; $6,000 Family; no coverage for any member of a family unless $6,000 deductible is met	No coverage Out-of-Network	No coverage Out-of-Network
Coinsurance Percentage	In Network - 80% covered until out- of-pocket maximum is met	In Network - 80% covered until out-of-pocket maximum is met	In Network - 80% covered until out-of-pocket maximum is met	90% covered	In Network - 90% covered until out-of-pocket maximum is met	100% covered	In Network - 90% covered until out-of-pocket maximum is met
	Out of Network - 60% covered until out-of-pocket maximum is met; subject to Maximum Allowed Amount	Out of Network - 60% covered until out-of-pocket maximum is met; subject to Maximum Allowed Amount	Out of Network - 60% covered until out-of-pocket maximum is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered until out-of-pocket maximum is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Out-of-pocket Maximum: Individual/Family	In Network - $2,500 Individual; $7,500 Family; in & out-of-network maximums are exclusive of each other; includes deductible and copays	In Network - $3,000 Individual; $9,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible	In Network - $5,000 Individual; $10,000 Family; in & out- of-network maximums are exclusive of each other; includes deductible and Rx Maximum Allowed Amount	$1,000 Individual; $3,000 Family; includes copays	In Network - $3,000 Individual; $6,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and Rx Maximum Allowed Amount A family must satisfy the family out of pocket maximum before the out of pocket maximum will be met for any family member	$1,500 Individual; $3,000 Family; copays included; excluding durable medical equipment, prescription drugs and infertility services	$3,200 Individual; $6,400 Family
	Out of Network - $7,000 Individual; $21,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and copays	Out of Network - $6,000 Individual; $18,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible	Out of Network - $10,000 Individual; $20,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and Rx Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - $6,000 Individual; $12,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and Rx Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Ability To Self-Refer To Specialists	Yes	Yes	Yes	Yes	Yes	Check with your guidebook to see if your facility has departments that don't require a referral	Check with your guidebook to see if your facility has departments that don't require a referral
				No coverage Out-of-Network		No coverage Out-of-Network	No coverage Out-of-Network

2024 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser HDHP
Primary Doctor Office Visit	In Network - $25 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$25 copay	In Network - 90% covered after deductible is met	$25 copay	In Network - 90% covered after deductible is met
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Specialist Office Visit	In Network - $35 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$35 copay	In Network - 90% covered after deductible is met	$35 copay	In Network - 90% covered after deductible is met
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Preventive Care	In Network - 100% covered	In Network - 100% covered	In Network - 100% covered	100% covered	In Network - 100% covered	100% covered; for preventive	100% covered; for preventive
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Mammogram	In Network - Diagnostic: 80% after deductible is met; 100% covered for preventive care	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care	Diagnostic: 90% covered; 100% covered for preventive care	In Network - Diagnostic: 90% covered after deductible is met; 100% covered for preventive care	100% covered for preventive care	90% covered after deductible is met; 100% covered for preventive care
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Immunizations (child)	In Network - 100% covered for preventive care	In Network - 100% covered for preventive care	In Network - 100% covered for preventive care	100% covered for preventive care	In Network - 100% covered for preventive care	100% covered for preventive care	100% covered for preventive care
	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network

2024 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser HDHP
Allergy Tests And Treatments	In Network – Diagnostic test/ diagnostic treatment: $25 copay PCP, $35 copay Specialist; allergy injections 100% covered	In Network – Diagnostic test/ diagnostic treatment: 80% covered after deductible is met; allergy injections 100% covered	In Network – Diagnostic test/ diagnostic treatment: 80% covered after deductible is met	Diagnostic test/diagnostic treatment: $25 copay PCP, $35 copay Specialist; allergy injections 100% covered	In Network – Diagnostic test/ diagnostic treatment: 90% covered after deductible is met	Diagnostic and testing: $25 copay per visit, allergy injections: $5 copay per visit	In Network – Diagnostic test/diagnostic treatment: 90% covered after deductible is met
	Out of Network – Diagnostic test/ diagnostic treatment: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network – Diagnostic test/diagnostic treatment: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network – Diagnostic test/diagnostic treatment: 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network – Diagnostic test/diagnostic treatment: 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Outpatient x-ray and laboratory services	In Network – 80% covered after deductible is met	In Network – 80% covered after deductible is met	In Network – 80% covered after deductible is met	90% covered	In Network – 90% covered after deductible is met	100% covered	In Network – 90% covered after deductible is met
	Out of Network – 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network – 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network – 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network – 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Outpatient Surgery	In Network – 80% covered after deductible is met	In Network – 80% covered after deductible is met	In Network – 80% covered after deductible is met	90% covered	In Network – 90% covered after deductible is met	$150 copay; per procedure	In Network – 90% covered after deductible is met
	Out of Network – 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network – 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network – 60% covered after deductible is met; subject to Maximum Allowed Amount; benefit limited to $350/visit	No coverage Out-of-Network	Out of Network – 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Outpatient Physical, Speech And Occupational Therapy	In Network – $25 copay; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network	In Network – 80% covered after deductible is met; limited to limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network	In Network – 80% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network	$25 copay; limited to 60 visits per year combined physical, speech and occupational therapy	In Network – 90% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network	$25 copay; per visit	In Network – 90% covered after deductible is met
	Out of Network – 60% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in- network and out-of-network; subject to Maximum Allowed Amount limits	Out of Network – 60% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network; subject to Maximum Allowed Amount limits	Out of Network – 60% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network; subject to Maximum Allowed Amount limits	No coverage Out-of-Network	Out of Network – 70% covered after deductible is met; limited to 60 visits per year combined physical, speech and occupational therapy, in-network and out-of-network; subject to Maximum Allowed Amount limits	No coverage Out-of-Network	No coverage Out-of-Network
Fertility Services (excludes in vitro fertilization)	In Network only – 50% covered after deductible is met; $20,000 lifetime maximum for all infertility benefits combined; medical and pharmacy	Not covered	Not covered	In Network only – 50% covered; $20,000 lifetime maximum for all infertility benefits combined; medical and pharmacy	Not covered	Covered at 50% member rate; for diagnosis and treatment of involuntary infertility when approved by a Plan physician	Not covered

2024 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser HDHP
In-patient Hospital Services (including physician, surgeon, lab and x-ray)	In Network - $250 copay per admission; then 80% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized	In Network - 80% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized	In Network - 80% covered after deductible is met	$250 copay per admission; then 90% covered; $200 penalty if nonemergency services are not preauthorized	In Network - 90% covered after deductible is met	$500 copay per admission	In Network - 90% covered after deductible is met
	Out of Network - 60% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Emergency Room (not followed by admission)	In Network - $100 copay; then 80% covered after deductible is met; copay waived if admitted	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	In-Network: $100 copay; then 90% covered after deductible is met; copay waived if admitted	In Network - 90% covered after deductible is met	$100 copay; waived if admitted	In Network - 90% covered after deductible is met
	Out of Network - $100 copay then 80% covered after deductible is met; copay waived if admitted	Out of Network - 80% covered after deductible is met	Out of Network - 80% covered after deductible is met; non-emergencies subject to Maximum Allowed Amount	Out-of-Network: $100 copay for emergencies then 90% covered after deductible is met; copay waived if admitted	Out of Network - 90% covered after deductible is met	$100 copay; waived if admitted	Out of Network - 90% covered after deductible is met
Urgent Care Clinic Visit	In Network - $25 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$25 copay	In Network - 90% covered after deductible is met	$25 copay; per visit	In Network - 90% covered after deductible is met
	Out of Network - 60% covered; after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Maximum Allowed Amount	$25 copay; per visit; non-Plan providers covered when outside the service area	Out of Network - 90% covered after deductible is met
Ambulance Services	In Network - 80% covered after deductible is met; must be medically necessary	In Network - 80% covered after deductible is met; must be medically necessary	In Network - 80% covered after deductible is met; must be medically necessary	In Network - 90% covered; must be medically necessary	In Network - 90% covered after deductible is met; must be medically necessary	$50 copay per trip	In Network - 90% covered after deductible is met
	Out of Network - 80% covered after deductible is met; no copay if true emergency; must be medically necessary; subject to Maximum Allowed Amount	Out of Network - 80% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount	Out of Network - 80% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount	Out of Network - 90% covered; must be medically necessary; subject to Maximum Allowed Amount	Out of Network - 90% covered after deductible is met; must be medically necessary; subject to Maximum Allowed Amount		Out of Network - 90% covered after deductible is met
Mental Health: Outpatient Coverage	In-network: $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network: $25 copay with no deductible.	In-network: 80% covered after deductible is met	In-network: $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network: 90% covered after deductible is met	$25 copay individual visit; $12 copay group visit; unlimited visits	In Network - 90% covered after deductible is met
	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of- Network	No coverage Out-of- Network

2024 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser HDHP
Mental Health: Inpatient Coverage	In-network: 80% covered after deductible is met	In-network: $25 co-pay with no deductible	In-network: 80% covered after deductible is met	In-network: 90% covered	In-network: 90% covered after deductible is met	$500 copay per admission	In Network - 90% covered after deductible is met
	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Substance Abuse: Outpatient Coverage	In-network: $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network: $25 co-pay with no deductible	In-network: 80% covered after deductible is met	In-network: $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network: 90% covered after deductible is met	$25 copay individual visit; $5 copay group visit; unlimited visits	In-network: 90% covered after deductible is met
	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Substance Abuse: Inpatient Coverage	In-network: 80% covered after deductible is met	In-network: 80% covered after deductible is met	In-network: 80% covered after deductible is met	In-network: 90% covered	In-network: 90% covered after deductible is met	$500 copay per admission; $100 copay for transitional residential recovery services; mental health/ chemical dependency services accrue to out- of-pocket maximum	In-network: 90% covered after deductible is met
	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	Out-of-network: 60% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out-of-network: 70% covered after deductible is met; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network
Chiropractic/ Acupuncture	In Network - $25 copay; limited to 25 visits per calendar year	In Network - 80% covered after deductible is met; limited to 25 visits per calendar year	In Network - 80% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network	$25 copay; limited to 25 visits per calendar year	In Network - 90% covered after deductible is met; limited to 25 visits per calendar year	Member discounts available through American Specialty Health network. Medically refereed acupuncture covered at primary care cost	Member discounts available through American Specialty Health network. Medically refereed acupuncture covered at primary care cost.
	Out of Network - 60% covered after deductible is met; limited to 25 visits per calendar year; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; limited to 25 visits per calendar year; subject to Maximum Allowed Amount	Out of Network - 60% covered after deductible is met; limited to 25 visits per calendar year; combined in- network and out-of-network; subject to Maximum Allowed Amount	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; limited to 25 visits per calendar year; subject to Maximum Allowed Amount	No coverage Out-of-Network	No coverage Out-of-Network

2024 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser HDHP
Prescription Drug Vendor	Caremark	Caremark	Caremark	Caremark	Caremark	Kaiser	Kaiser
Prescription Drug Member Services	1-866-623-1438	1-866-623-1438	1-866-623-1438	1-866-623-1438	1-866-623-1438	1-800-464-4000	1-800-464-4000
Prescription Drug Web Site	www.caremark.com	www.caremark.com	www.caremark.com	www.caremark.com	www.caremark.com	www.kp.org/llns	www.kp.org/llns
Annual Prescription Deductible	Not applicable	Not applicable	Medical deductible applies; member pays 100% of the Rx cost until medical deductible is met	Not applicable	Medical deductible applies; member pays 100% of the Rx cost until medical deductible is met	Not applicable	Medical deductible applies; member pays 100% of the Rx cost until medical deductible is met
Prescription Benefits Are Covered Under Medical Deductible	No	No	Yes	No	Yes	Not applicable	Yes
Annual Rx Out-Of- Pocket Maximum	$2,800 Individual; $5,700 Family (in- network only)	$2,100 Individual; $4,200 Family (in-network only)	Medical out-of-pocket maximum applies; once medical out-of- pocket maximum is met, Rx is 100% covered for the remainder of the calendar year	$3,500 Individual; $7,000 Family	Medical out-of-pocket maximum applies; once medical out-of-pocket maximum is met, Rx is 100% covered for the remainder of the calendar year	Not applicable	Medical out-of-pocket maximum applies; once medical out-of-pocket maximum is met, Rx is 100% covered for the remainder of the calendar year
Retail Generic	In Network - $10 copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - $10 copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met	$10 copay; 30 day supply; Non-participating pharmacies: 50% of average whole price schedule plus charges above the schedule	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met	$15 for up to a 30-day supply; $45 for up to a 100-day supply; at Kaiser Pharmacy; as prescribed by Plan Physician	$10 for up to a 30-day supply; $30 for up to a 100-day supply after deductible is met
Retail Formulary Brand	In Network - 80% covered; $40 minimum copay, $60 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered; $40 minimum copay, $60 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met	80% covered; $40 minimum copay, $60 maximum copay; 30 day supply; Non-participating pharmacies: 50% of average whole price schedule plus charges above the schedule	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met	$35 for up to a 30-day supply; $105 for up to a 100-day supply; at Kaiser Pharmacy; as prescribed by Plan Physician	$30 for up to a 30-day supply; $90 for up to a 100-day supply after deductible is met
Retail Nonformulary Brand	In Network - 60% covered; $60 minimum copay, $100 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 60% covered; $60 minimum copay, $100 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met	60% covered; $60 minimum copay, $100 maximum copay; 30 day supply; Non-participating pharmacies: 50% of average whole price schedule plus charges above the schedule	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met	$35 for up to a 30-day supply; $105 for up to a 100-day supply; at Kaiser Pharmacy; as prescribed by Plan Physician	$30 for up to a 30-day supply; $90 for up to a 100-day supply after deductible is met
Mail Order Generic	$20 copay; 90 day supply; must use plan mail order facility	$20 copay; 90 day supply; must use plan mail order facility	80% covered after deductible is met	$20 copay; 90 day supply; must use plan mail order facility	90% covered after deductible is met	$15 for up to a 30-day supply; $30 for up to a 100-day supply; mail order as prescribed by Plan Physician	$10 for up to a 30-day supply; $20 for up to a 100-day supply after deductible is met
Mail Order Formulary Brand	80% covered; $80 minimum copay, $120 maximum copay; 90 day supply; must use plan mail order facility	80% covered; $80 minimum copay, $120 maximum copay; 90 day supply; must use plan mail order facility	80% covered after deductible is met	80% covered; $80 minimum copay, $120 maximum copay; 90 day supply; must use plan mail order facility	90% covered after deductible is met	$35 for up to a 30-day supply; $70 for up to a 100-day supply; mail order as prescribed by Plan Physician	$30 for up to a 30-day supply; $60 for up to a 100-day supply after deductible is met
Mail Order Nonformulary Brand	60% covered; $120 minimum copay, $200 maximum copay; 90 day supply; must use plan mail order facility	60% covered; $120 minimum copay, $200 maximum copay; 90 day supply; must use plan mail order facility	80% covered after deductible is met	60% covered; $120 minimum copay, $200 maximum copay; 90 day supply; must use plan mail order facility	90% covered after deductible is met	$35 for up to a 30-day supply; $70 for up to a 100-day supply; mail order as prescribed by Plan Physician and deemed medically necessary	$30 for up to a 30-day supply; $60 for up to a 100-day supply after deductible is met

Note: If there is a discrepancy between the benefits as described in the charts and the plan administrator's systems, the plan administrator's system governs for determining benefit coverage.