2024 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

	FOR THOSE NOT MEDICARE ELIGIBLE						FOR THOSE MEDICARE ELIGIBLE
	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
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	1-800-443-0815 (KPSA Member Services)
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
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	$0 Individual; $0 Family
	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 Out-of-Network Coverage
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	100% Covered
	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 Out-of-Network Coverage
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	$1,500 Individual; $3,000 Family: Copay included excluding durable medical equipment, prescription drugs and infertility services.
	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 Out-of-Network Coverage
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 Out-of-Network Coverage

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.

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FOR THOSE NOT MEDICARE ELIGIBLE							FOR THOSE MEDICARE ELIGIBLE
	Anthem Blue Cross Plus	**Anthem Blue Cross PPO**	**Anthem Blue Cross Core Value**	**Anthem Blue Cross EPO Exclusive**	**Anthem Blue Cross HDHP**	**Kaiser**	**Kaiser Senior Advantage**
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	$25 Copay
	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	Not Applicable
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	$25 Copay
	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	Not Applicable
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: $35 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	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

FOR THOSE NOT MEDICARE ELIGIBLE

FOR THOSE MEDICARE ELIGIBLE

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
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	Diagnostic and testing: $25 copay per visit; allergy injection: $3 copay per visit.
	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 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	$25 copay; per procedure
	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	$25 copay; per visit
	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	Refer to EOC

2024 MEDICAL PLAN OPTIONS COMPARISON OF BENEFIT COVERAGES

	FOR THOSE NOT MEDICARE ELIGIBLE						FOR THOSE MEDICARE ELIGIBLE
	Anthem Blue Cross Plus	**Anthem Blue Cross PPO**	**Anthem Blue Cross Core Value**	**Anthem Blue Cross EPO Exclusive**	**Anthem Blue Cross HDHP**	**Kaiser**	**Kaiser Senior Advantage**
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	$250 Copay Per Admission
	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 unless medical emergency
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	$50 Copay; waived if admitted
	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	Check with Plan
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	$25 Copay; Per Visit
	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	Check with Plan
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	$50 Copay Per Trip
	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		$50 Copay Per Trip
Mental Health: Outpatient Coverage	In-network: $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network: Behavior Health visits, the deuctible is waived; co-pay is $25.	In-network: Behavior Health visits, the deuctible is waived; co-pay is $25.	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	$25 Copay; Individual visit; $12 Copay group visit; Unlimited Visits
	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

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	FOR THOSE NOT MEDICARE ELIGIBLE						FOR THOSE MEDICARE ELIGIBLE
	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
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	$250 Copay Per Admission
	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	$25 Copay; $5 Copay Group Visit; Unlimited Visits
	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	$250 Copay per admission; $100 Copay for transitional residential recovery services; mental health/ chemical dependency services accrue to out-of-pocket maximum
	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	Not Applicable
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
	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	Not Applicable

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	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser	Kaiser Senior Advantage
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	1-800-443-0815 (KPSA Member Services)
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	Not applicable
Prescription Benefits Are Covered Under Medical Deductible	No	No	Yes	No	Yes	Not applicable	Not applicable
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	Not applicable
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; at Kaiser Pharmacy; as prescribed by Plan Physician
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	$25 for up to a 30-day supply; $75 for up to 100-day supply; at Kaiser Pharmacy; as prescribed by Plan Physician
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	Covered only when determined medically necessary by a plan physician Note: Most specialty drugs have a 20% coinsurance (not to exceed $150) for up to 100-day supply.