

**MEDICAL****2023 MEDICAL& PHARMACY (RX) PLAN DESIGNS COMPARISON (Same as 2022)**

	<b>ANTHEM HSA PLAN*</b>		<b>ANTHEM POS PLAN*</b>		<b>KAISER HMO PLAN</b>	<b>ANTHEM HMO</b>
	<b>In-Network (Less Restrictive)</b>	<b>Out-of-Network</b>	<b>In-Network (Less Restrictive)</b>	<b>Out-of-Network</b>	<b>In-Network Only (Restrictive)</b>	<b>In-Network Only (Less Restrictive)</b>
<b>HSA Contribution</b>	\$750 Employee \$1,500 Emp +1 \$1,500 Family		Not Available		Not Available	Not Available
<b>Annual Deductible</b>	\$1,500 Employee \$3,000 Emp + 1 \$3,000 Family	\$3,000 Employee \$6,000 Emp + 1 \$6,000 Family	\$500 Employee \$750 Emp + 1 \$1,000 Family	\$1,000 Employee \$1,500 Emp + 1 \$2,000 Family	No deductible	No deductible
<b>Annual Out-of-Pocket Maximum</b>	\$3,000 Employee \$6,000 Emp + 1 \$6,000 Family	\$6,000 Employee \$12,000 Emp + 1 \$12,000 Family	\$2,000 Employee \$3,000 Emp+ 1 \$4,000 Family	\$4,000 Employee \$6,000 Emp+ 1 \$8,000 Family	\$6,450 Emp \$12,900 Family	\$6,450 Emp \$12,900 Family
<b>Coinsurance</b>	90%	60%	80%	60%	100%	100%
<b>Preventive Care</b>	100%, no deductible	60% after deductible	100%, no deductible	60%	100%	100%
<b>Office Visit</b>	90% after deductible	60% after deductible	\$30 PCP \$50 SPC	60% after deductible	\$25 PCP \$40 SPC	\$25 PCP \$40 SPC
<b>Hearing Aid Benefit</b>	90% after deductible	60% after deductible	80% after deductible	60% after deductible	100%, up to \$2,000 annual maximum	100%, up to \$2,000 annual maximum
<b>Outpatient Lab &amp; X-Ray</b>	90% after deductible	60% after deductible	80% after deductible	60% after deductible	100%	100%
<b>Hospital Emergency Room</b>	90% after deductible	90% after deductible	\$200 copay/visit (copay waived, if admitted)	\$200 copay/visit (copay waived, if admitted)	\$150 copay/visit (copay waived, if admitted)	\$150 copay/visit (copay waived, if admitted)
<b>Urgent Care</b>	90% after deductible	60% after deductible	\$50 copay/visit	60% after deductible	\$50 copay/visit at designated facilities	\$50 copay/visit at designated facilities
<b>Inpatient Hospital</b>	90% after deductible	60% after deductible	80% after deductible	60% after deductible	\$250 copay/admission	\$250 copay/admission
<b>Outpatient Hospital</b>	90% after deductible	60% after deductible	80% after deductible	60% after deductible	\$150 copay/visit	\$150 copay/visit



## 2023 MEDICAL & PHARMACY (RX) PLAN DESIGNS COMPARISON (Same as 2022)

### MEDICAL CONT'D

	ANTHEM HSA PLAN*		ANTHEM POS PLAN*		KAISER HMO PLAN	ANTHEM HMO
	In-Network (Less Restrictive)	Out-of-Network	In-Network (Less Restrictive)	Out of Network	In-Network Only (Restrictive)	In-Network Only (Less Restrictive)
<b>Maternity Care</b>	90% after deductible	60% after deductible	80% after deductible	60% after deductible	\$25 PCP/initial visit; \$35 OB/GYN/ initial visit; \$120 copay/admission	\$25 PCP/initial visit; \$35 OB/GYN/ initial visit; \$120 copay/admission
• Pre/Post Delivery Exams					\$120 copay for professional fees/ doctor	\$120 copay for professional fees/ doctor
• Delivery						
<b>Skilled Nursing Facility</b>	90% after deductible	60% after deductible	80% after deductible	60% after deductible	100%, up to 120 days/year	100%, up to 120 days/year
<b>Home Health Care</b>	90% after deductible	60% after deductible	80% after deductible	60% after deductible	100%, up to 120 days/year	100%, up to 120 days/year
<b>Mental Health Benefits</b>	90% after deductible	60% after deductible	80% after deductible	60% after deductible	\$25 copay	\$25 copay
• Outpatient					\$120 copay	\$120 copay
• Inpatient					100%	100%
• Intermediate/ Alternative Care						

### PHARMACY (RX)

<b>Retail (30-day supply)</b>	90% after deductible	60% after deductible	\$10 copay	60% after deductible	\$10 copay	\$10 copay
• Generic						
• Preferred Brand			\$35 copay		\$30 copay	\$30 copay
• Non-Preferred Brand			\$60 copay		\$50 copay	\$50 copay
• Specialty Brand			\$100 copay		\$75 copay	\$75 copay
<b>Mail Order (90-day supply)</b>	90% after deductible	Not Available	\$20 copay	Not Available	\$20 copay	\$20 copay
• Generic						
• Preferred Brand			\$60 copay		\$60 copay	\$60 copay
• Non-Preferred Brand			\$100 copay		\$100 copay	\$100 copay
• Specialty Brand			\$150 copay		\$150 copay	\$150 copay

- If you are enrolled in the Anthem POS or HMO Plan and use Grady Health System providers, no deductibles, copays, or coinsurance payments are required.
- If you are enrolled in the HSA Plan and use Grady Health System providers, services will be covered at 100%, after deductible.