# Medical - Washington

## 2027 Medical Plan Comparison

| | Anthem High Deductible PPO | | Kaiser WA HMO |
|---|---|---|---|
| | In Network | Out of Network* | Kaiser WA providers only. No out-of-network coverage. |
| **Preventive Care** | 100%, no deductible | 60% covered after deductible | 100% |
| **Deductible** | $3,500 per person<br>$7,000 per family | | No deductible |
| **Out-of-Pocket Maximum** | $4,500 per person<br>$9,000 per family | $8,000 per person<br>$16,000 per family | $1,000 per person<br>$2,000 per family |
| **Primary Care Physician** | 80% covered after deductible | 60% covered after deductible | $15 copay per visit |
| **Specialist** | 80% covered after deductible | 60% covered after deductible | $15 copay per visit |
| **Telehealth** | $0 through LiveHealth Online | 60% covered after deductible | $0 copay |
| **Emergency Room** | 80% of eligible charges covered after deductible | | $200 copay<br>(waived if admitted)** |
| **Urgent Care** | 80% covered after deductible | 60% covered after deductible | $15 copay |
| **Hospital Stay** | 80% covered after deductible | 60% covered after deductible | 100% covered |
| **Eligible Health Care Spending Accounts** | Health Savings Account (HSA) and Healthcare Flexible Spending Account (HFSA) | | Healthcare Flexible Spending Account (HFSA) |

*Out-of-network providers may bill members for the difference between the provider's full charges and the amount paid by the plan.
**If out of network, notify Kaiser within 24 hours; out-of-network follow-up care is not covered.

## Monthly Employee Premiums

| | Employee Only | Employee + Child(ren) | Employee + Spouse | Employee + Family |
|---|---|---|---|---|
| **Anthem High Deductible PPO** | $83 | $177 | $202 | $320 |
| **Kaiser WA HMO** | $187 | $395 | $459 | $712 |

# Prescriptions - Washington

| | Anthem High Deductible PPO | | Kaiser WA HMO |
|---|---|---|---|
| | Retail Pharmacy | | |
| | In Network<br>Participating Providers<br>(Up to 30-Day Supply) | Out of Network*<br>Non-Participating Providers<br>(Up to 30-Day Supply) | Participating Providers<br>(Up to 30-Day Supply) |
| **Preventive** | *Deductible waived* | *Deductible applies* | *No deductible* |
| **Generic** | $15 copay | 60% after deductible | $10 copay |
| **Brand-name formulary** | $45 copay | 60% after deductible | $40 copay |
| **Brand-name non-formulary** | $75 copay | 60% after deductible | |
| **Non-Preventive** | *Deductible applies* | *Deductible applies* | *No deductible* |
| **Generic** | 20% coinsurance up to $100 per prescription, after deductible | 60% after deductible | $10 copay |
| **Brand-name formulary** | 20% coinsurance up to $250 per prescription, after deductible | 60% after deductible | $40 copay |
| **Brand-name non-formulary** | 20% coinsurance up to $250 per prescription, after deductible | 60% after deductible | |

*Out-of-network providers may bill members for the difference between the provider's full charges and the amount paid by the plan.

# Prescriptions - Washington

| | Anthem High Deductible PPO | | Kaiser WA HMO |
|---|---|---|---|
| | **Mail Order** | | |
| | In Network Participating Providers (Up to 90-Day Supply) | Out of Network Non-Participating Providers (Up to 90-Day Supply) | Participating Providers (Up to 90-Day Supply) |
| **Preventive** | *Deductible waived* | *Deductible applies* | *No deductible* |
| **Generic** | $30 copay | Not covered | $20 copay |
| **Brand-name formulary** | $90 copay | Not covered | $80 copay |
| **Brand-name non-formulary** | $150 copay | Not covered | |
| **Non-Preventive** | *Deductible applies* | *Deductible applies* | *No deductible* |
| **Generic** | 20% coinsurance up to $200 per prescription, after deductible | Not covered | $20 copay |
| **Brand-name formulary** | 20% coinsurance up to $500 per prescription, after deductible | Not covered | $80 copay |
| **Brand-name non-formulary** | 20% coinsurance up to $500 per prescription, after deductible | Not covered | |

| | Specialty Pharmacy | | |
|---|---|---|---|
| | Participating Providers (Up to 30-Day Supply) | Non-Participating Providers | Participating Providers (Up to 30-Day Supply) |
| **Specialty** | $75 copay | Not covered | Not covered |

# Medical - Owens Valley

## 2027 Medical Plan Comparison

| | Anthem High Deductible PPO | | Anthem Owens Valley PPO |
|---|---|---|---|
| | In Network | Out of Network* | Anthem Owens Valley providers only. No out-of-network coverage.* |
| **Preventive Care** | 100%, no deductible | 60% covered after deductible | 100% |
| **Deductible** | $3,500 per person<br>$7,000 per family | | No deductible |
| **Out-of-Pocket Maximum** | $4,500 per person<br>$9,000 per family | $8,000 per person<br>$16,000 per family | N/A |
| **Primary Care Physician** | 80% covered after deductible | 60% covered after deductible | $15 copay per visit |
| **Specialist** | 80% covered after deductible | 60% covered after deductible | $15 copay per visit |
| **Telehealth** | $0 through LiveHealth Online | 60% covered after deductible | $0 through LiveHealth Online |
| **Emergency Room** | 80% of eligible charges covered after deductible | | $250 copay (waived if admitted), then 100% covered |
| **Urgent Care** | 80% covered after deductible | 60% covered after deductible | $15 copay per visit |
| **Hospital Stay** | 80% covered after deductible | 60% covered after deductible | $250 copay per admission, then 100% covered** |
| **Eligible Health Care Spending Accounts** | Health Savings Account (HSA) and Healthcare Flexible Spending Account (HFSA) | | Healthcare Flexible Spending Account (HFSA) |

*Out-of-network providers may bill members for the difference between the provider's full charges and the amount paid by the plan.
**Additional $500 deductible applies if you do not receive preauthorization for a non-emergency hospital admission.

## Monthly Employee Premiums

| | Employee Only | Employee + Child(ren) | Employee + Spouse | Employee + Family |
|---|---|---|---|---|
| **Anthem High Deductible PPO** | $83 | $177 | $202 | $320 |
| **Anthem Owens Valley** | $187 | $395 | $459 | $712 |

# Prescriptions - Owens Valley

| | Anthem High Deductible PPO | | Anthem Owens Valley PPO |
|---|---|---|---|
| | Retail Pharmacy | | |
| | In Network Participating Providers (Up to 30-Day Supply) | Out of Network* Non-Participating Providers (Up to 30-Day Supply) | Participating Providers (Up to 30-Day Supply) |
| **Preventive** | *Deductible waived* | *Deductible applies* | *No deductible* |
| **Generic** | $15 copay | 60% after deductible | $15 copay |
| **Brand-name formulary** | $45 copay | 60% after deductible | $45 copay |
| **Brand-name non-formulary** | $75 copay | 60% after deductible | $75 copay |
| **Non-Preventive** | *Deductible applies* | *Deductible applies* | *No deductible* |
| **Generic** | 20% coinsurance up to $100 per prescription, after deductible | 60% after deductible | $15 copay |
| **Brand-name formulary** | 20% coinsurance up to $250 per prescription, after deductible | 60% after deductible | $45 copay |
| **Brand-name non-formulary** | 20% coinsurance up to $250 per prescription, after deductible | 60% after deductible | $75 copay |

*Out-of-network providers may bill members for the difference between the provider's full charges and the amount paid by the plan.

# Prescriptions - Owens Valley

| | Anthem High Deductible PPO | | Anthem Owens Valley PPO |
|---|---|---|---|
| | **Mail Order** | | |
| | In Network Participating Providers (Up to 90-Day Supply) | Out of Network Non-Participating Providers (Up to 90-Day Supply) | Participating Providers (Up to 90-Day Supply) |
| **Preventive** | *Deductible waived* | *Deductible applies* | *No deductible* |
| **Generic** | $30 copay | Not covered | $30 copay |
| **Brand-name formulary** | $90 copay | Not covered | $90 copay |
| **Brand-name non-formulary** | $150 copay | Not covered | $150 copay |
| **Non-Preventive** | *Deductible applies* | *Deductible applies* | *No deductible* |
| **Generic** | 20% coinsurance up to $200 per prescription, after deductible | Not covered | $30 copay |
| **Brand-name formulary** | 20% coinsurance up to $500 per prescription, after deductible | Not covered | $90 copay |
| **Brand-name non-formulary** | 20% coinsurance up to $500 per prescription, after deductible | Not covered | $150 copay |

| | **Specialty Pharmacy** | | |
|---|---|---|---|
| | In Network Participating Providers (Up to 30-Day Supply) | Non-Participating Providers | Participating Providers (Up to 30-Day Supply) |
| **Specialty** | $75 copay | Not covered | Not covered |

# Medical - Other Locations

## 2027 Medical Plan Comparison

| | Anthem High Deductible PPO | | Anthem BlueCard PPO | |
|---|---|---|---|---|
| | In Network | Out of Network* | In Network | Out of Network* |
| **Preventive Care** | 100%, no deductible | 60% covered after deductible | 100%, no deductible | 20% coinsurance |
| **Deductible** | $3,500 per person<br>$7,000 per family | | $250 per person<br>$750 family | $750 per person<br>$2,250 per family |
| **Out-of-Pocket Maximum** | $4,500 per person<br>$9,000 per family | $8,000 per person<br>$16,000 per family | $1,500 per person<br>$3,000 per family | $2,000 per person<br>$4,000 per family |
| **Primary Care Physician** | 80% covered after deductible | 60% covered after deductible | $20 copay per visit (deductible does not apply) | 20% coinsurance |
| **Specialist** | 80% covered after deductible | 60% covered after deductible | $20 copay per visit (deductible does not apply) | 20% coinsurance |
| **Telehealth** | $0 through LiveHealth Online | 60% covered after deductible | $0 through LiveHealth Online | 20% coinsurance |
| **Emergency Room** | 80% of eligible charges covered after deductible | | $250 copay (waived if admitted) and then 0% coinsurance for facility, doctor and other services | Covered as in network |
| **Urgent Care** | 80% covered after deductible | 60% covered after deductible | $20 copay per visit (deductible does not apply) | 20% coinsurance |
| **Hospital Stay** | 80% covered after deductible | 60% covered after deductible | 0% coinsurance with $250 deductible for facility fees** | 20% coinsurance |
| **Eligible Health Care Spending Accounts** | Health Savings Account (HSA) and Healthcare Flexible Spending Account (HFSA) | | Healthcare Flexible Spending Account (HFSA) | |

*Out-of-network providers may bill members for the difference between the provider's full charges and the amount paid by the plan.
**Additional $500 deductible applies if you do not receive preauthorization for a non-emergency hospital admission.

## Monthly Employee Premiums

| | Employee Only | Employee + Child(ren) | Employee + Spouse | Employee + Family |
|---|---|---|---|---|
| **Anthem High Deductible PPO** | $83 | $177 | $202 | $320 |
| **Anthem BlueCard PPO** | $187 | $395 | $459 | $712 |

# Prescriptions - Other Locations

| | Anthem High Deductible PPO | | Anthem BlueCard PPO | |
|---|---|---|---|---|
| | Retail Pharmacy | | | |
| | In Network Participating Providers (Up to 30-Day Supply) | Out of Network* Non-Participating Providers (Up to 30-Day Supply) | In Network Participating Providers (Up to 30-Day Supply) | Out of Network Non-Participating Providers (Up to 30-Day Supply)* |
| **Preventive** | *Deductible waived* | *Deductible applies* | *No deductible* | *No deductible* |
| **Generic** | $15 copay | 60% after deductible | $15 copay | 50% after $15 copay |
| **Brand-name formulary** | $45 copay | 60% after deductible | $45 copay | 50% after $45 copay |
| **Brand-name non-formulary** | $75 copay | 60% after deductible | $75 copay | 50% after $150 copay |
| **Non-Preventive** | *Deductible applies* | *Deductible applies* | *No deductible* | *No deductible* |
| **Generic** | 20% coinsurance up to $100 per prescription, after deductible | 60% after deductible | $15 copay | 50% after $15 copay |
| **Brand-name formulary** | 20% coinsurance up to $250 per prescription, after deductible | 60% after deductible | $45 copay | 50% after $45 copay |
| **Brand-name non-formulary** | 20% coinsurance up to $250 per prescription, after deductible | 60% after deductible | $75 copay | 50% after $150 copay |

*Out-of-network providers may bill members for the difference between the provider's full charges and the amount paid by the plan.

# Prescriptions - Other Locations

| | Anthem High Deductible PPO | | Anthem BlueCard PPO | |
|---|---|---|---|---|
| | **Mail Order** | | | |
| | In Network Participating Providers (Up to 90-Day Supply) | Out of Network Non-Participating Providers (Up to 90-Day Supply) | In Network Participating Providers (Up to 90-Day Supply) | Out of Network Non-Participating Providers (Up to 90-Day Supply) |
| **Preventive** | *Deductible waived* | | *No deductible* | |
| **Generic** | $30 copay | Not covered | $30 copay | Not covered |
| **Brand-name formulary** | $90 copay | Not covered | $90 copay | Not covered |
| **Brand-name non-formulary** | $150 copay | Not covered | $150 copay | Not covered |
| **Non-Preventive** | *Deductible applies* | | *No deductible* | |
| **Generic** | 20% coinsurance up to $200 per prescription, after deductible | Not covered | $30 copay | Not covered |
| **Brand-name formulary** | 20% coinsurance up to $500 per prescription, after deductible | Not covered | $90 copay | Not covered |
| **Brand-name non-formulary** | 20% coinsurance up to $500 per prescription, after deductible | Not covered | $150 copay | Not covered |

| | **Specialty Pharmacy** | | | |
|---|---|---|---|---|
| | Participating Providers (Up to 30-Day Supply) | Non-Participating Providers | Participating Providers (Up to 30-Day Supply) | Non-Participating Providers |
| **Specialty** | $75 copay | Not covered | $75 copay | Not covered |

# Hawaii

## 2027 Medical Plan

| | Hawaii Medical Service Association |
|---|---|
| **Preventive Care** | 100% |
| **Deductible** | No deductible |
| **Out-of-Pocket Maximum** | $2,500 per person<br>$7,500 per family |
| **Primary Care Physician** | $14 copay per visit |
| **Specialist** | $14 copay per visit |
| **Emergency Room** | Facility: 20% coinsurance<br>Provider: $20 copay |
| **Urgent Care** | $14 copay per visit |
| **Hospital Stay** | Facility: 20% coinsurance<br>Provider: $20 copay |
| **Eligible Health Care Spending Accounts** | Healthcare Flexible Spending Account (HFSA) |

## Monthly Employee Premiums

**HMSA: CompMED Choice Med w/RX & Vision**

| | |
|---|---|
| **Employee Only** | $0 |
| **Employee + Child(ren)** | $459 EE + Child<br>$712 EE + Children |
| **Employee + Spouse** | $459 |
| **Employee + Family** | $712 |

## Prescriptions

| | Hawaii Medical Service Association | |
|---|---|---|
| | **Retail Pharmacy** | |
| | Participating Providers (Up to 30-Day Supply) | Non-Participating Providers (Up to 30-Day Supply) |
| **Generic** | $7 copay | 20% after $7 copay |
| **Brand-name formulary** | $30 copay | 20% after $30 copay |
| **Brand-name non-formulary** | $30 copay* | 20% after $30 copay* |

| | **Mail Order** | |
|---|---|---|
| | Participating Providers (Up to 90-Day Supply) | Non-Participating Providers |
| **Generic** | $11 copay | Not covered |
| **Brand-name formulary** | $65 copay | Not covered |
| **Brand-name non-formulary** | $65 copay* | Not covered |

| | **Specialty Pharmacy** | |
|---|---|---|
| | Participating Providers (Up to 30-Day Supply) | Non-Participating Providers |
| **Specialty** | $100 copay | Not covered |
| **Non-preferred Specialty** | $200 copay | Not covered |