CSEBO MEDICAL INSURANCE
DEDUCTIBLE HEALTH PLANS
EFFECTIVE 1/1/2023 - 12/31/2023

CARRIER	ANTHEM BLUE CROSS						KAISER PERMANENTE
PLAN NAME	PPO 90		PPO 80		CDHP 90		CDHP
GENERAL PLAN INFORMATION	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK ONLY
Annual Medical Out-of-Pocket Limit							
Individual/Individual in Family/Family	$2,000/$2,000/$6,000[2]	Unlimited	$3,000/$3,000/$9,000[2]	Unlimited	$3,000/$6,000/$6,000 (Combined Medical & Rx Out-of-Pocket Max)	Unlimited	$3,000/$3,000/$6,000[3] (Combined Medical & Rx Out-of-Pocket Max)
Annual Medical Deductible - Plan Deductible Applies Unless Otherwise Stated							
Individual/Family	$500/$500/$1,500[2]	$1,000/$1,000/$3,000[2]	$750/$750/$2,250[2]	$1,500/$1,500/$4,500[2]	$1,500/$3,000/$3,000 (Combined Medical & Rx Deductible)	$4,000/$8,000/$8,000 (Combined Medical & Rx Deductible)	$1,500/$3,000/$3,000 (Combined Medical & Rx Deductible)
Plan Information							
Type of Plan	Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Health Maintenace Organization (HMO)
Referrals Required?	No		No		No		Yes
Plan Coinsurance	Plan Pays 90% (After Deductible)	50% Coinsurance (After Deductible)	Plan Pays 80% (After Deductible)	50% Coinsurance (After Deductible)	Plan Pays 90% (After Deductible)	50% Coinsurance (After Deductible)	Plan Pays 90% (After Deductible)
Health Savings Account (HSA) Compatibility:							
HSA-Compatible Plan?	No		No		Yes		Yes
2023 Individual Maximum Contribution	N/A		N/A		$3,850		$3,850
2023 Family Maximum Contribution	N/A		N/A		$7,750		$7,750
Over 55 HSA Contribution Catch-Up	N/A		N/A		$1,000		$1,000
Physician/Diagnostic Services							
Preventive Care	$0 (Deductible Waived)	Not Covered	$0 (Deductible Waived)	Not Covered	$0 (Deductible Waived)	Not Covered	$0
Primary Care Office Visit	$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)
Specialist Office Visit	$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)
Diagnostic X-Ray and Lab Tests	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)
Advanced Imaging (MRI/PET/CAT Scans)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $800 per procedure maximum	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $800 per procedure maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $800 per procedure maximum	10% Coinsurance (After Deductible)
Inpatient Hospital Services							
Inpatient Hospitalization	10%[4] Coinsurance (After Deductible)	50%[4] Coinsurance (After Deductible) up to $1,000 maximum per day	20%[4] Coinsurance (After Deductible)	50%[4] Coinsurance (After Deductible) up to $1,000 maximum per day	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $1,000 maximum per day	10% Coinsurance (After Deductible)
Outpatient Services							
Outpatient Surgery	10%[4] Coinsurance (After Deductible)	50%[4] Coinsurance (After Deductible) up to $350 per day maximum	20%[4] Coinsurance (After Deductible)	50%[4] Coinsurance (After Deductible) up to $350 per day maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $350 per day maximum	10% Coinsurance (After Deductible)
Outpatient Lab and Imaging	10%[4] Coinsurance (After Deductible)	50%[4] Coinsurance (After Deductible) up to $350 per procedure maximum	20%[4] Coinsurance (After Deductible)	50%[4] Coinsurance (After Deductible) up to $350 per procedure maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $350 per procedure maximum	10% Coinsurance (After Deductible)
Emergency Services							
Ambulance Services	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)
Emergency Room	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)

[1]When using out-of-network providers, you are responsible for the deductible, coinsurance, and additional amounts exceeding the usual and customary charges.

[2]The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

[3]The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum. In addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum.

[4]$250 deductible applies if utilization review is not obtained (waived for emergency admissions and outpatient freestanding surgery centers).

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Urgent Care							
Urgent Care Visits	$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)
Mental Health and Substance Abuse							
Inpatient Mental Health	10%[4] Coinsurance (After Deductible)	50%[4] Coinsurance (After Deductible) up to $1,000 per day maximum	20%[4] Coinsurance (After Deductible)	50%[4] Coinsurance (After Deductible) up to $1,000 per day maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $1,000 per day maximum	10% Coinsurance (After Deductible)
Outpatient Mental Health Office Visit	$10 copay	50% Coinsurance (After Deductible)	$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)
Other Outpatient Mental Health Services	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)
Other Practitioner Visits							
Acupuncture	10% Coinsurance (After Deductible)	Not Covered	20% Coinsurance (After Deductible)	Not Covered	10% Coinsurance (After Deductible), maximum of 20 visits per calendar year, then plan pays 0%	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	N/A
Chiropractor Services	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	10% Coinsurance (After Deductible), maximum of 30 visits per calendar year, then plan pays 0%	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	N/A
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK ONLY**
Annual Prescription Drug Out-of-Pocket Limit							
Individual/Individual in Family/Family	$2,000/$2,000/$4,000[2]	Unlimited	$2,000/$2,000/$4,000[2]	Unlimited	Combined with Medical	Unlimited	Combined with Medical
Annual Prescription Drug Deductible							
Per Individual	$0		$0		Combined with Medical		Combined with Medical
Prescription Drug Formulary							
Formulary (Covered Drugs)	National 3-Tier		National 3-Tier		National 4-Tier		CA Commercial 3-Tier
Retail	**30-Day Supply**		**30 days**		**30 days**		**30 days**
Generic	$5 min Copay/ or 20% up to a $25 Max Copay (Deductible Waived)	Paper claim submission required	$10 Copay (Deductible Waived)	Paper claim submission required	$10 Copay (After Deductible)	Paper claim submission required	$10 Copay (After Deductible)
Brand (Formulary/Preferred)			$20 Copay (Deductible Waived)		$30 Copay (After Deductible)		$30 Copay (After Deductible)
Brand (Non-Formulary/Non-Preferred)			$35 Copay (Deductible Waived)		$30 Copay (After Deductible)		$30 Copay (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	Same as Retail Brand		Same as Retail Brand		20% Coinsurance (After Deductible; Not to Exceed $150)		20% Coinsurance (After Deductible; Not to Exceed $150)
Mail Order	**90-Day Supply**		**90-Day Supply**		**90-Day Supply**		**100-Day Supply**
Generic	$5 Copay (Deductible Waived)	Paper claim submission required	$20 Copay (Deductible Waived)	Paper claim submission required	$20 Copay (After Deductible)	Paper claim submission required	$20 Copay (After Deductible)
Brand (Formulary/Preferred)			$40 Copay (Deductible Waived)		$60 Copay (After Deductible)		$60 Copay (After Deductible)
Brand (Non-Formulary/Non-Preferred)			$70 Copay (Deductible Waived)		$60 Copay (After Deductible)		$60 Copay (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)			$70 Copay (Deductible Waived)		20% Coinsurance (After Deductible; Not to Exceed $150)		20% Coinsurance (After Deductible; Not to Exceed $150)

[2]For Anthem PPO 90 & 80: The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

[4]$250 deductible applies if utilization review is not obtained (waived for emergency admissions and outpatient freestanding surgery centers).

Note: This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.