CSEBO MEDICAL INSURANCE
CONSUMER-DIRECTED HEALTH PLANS (CDHP) COMPARISON
EFFECTIVE 1/1/2023 - 12/31/2023

PLAN NUMBER	ANTHEM BLUE CROSS						KAISER PERMANENTE
	CDHP PPO 90		CDHP PPO 80		CDHP PPO 60		CDHP DHMO $1,500
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 and Prescription Drug Combined Out-of-Pocket Limit							
Individual/Individual in Family/Family	$3,000/$6,000/$6,000	Unlimited	$5,000/$5,000/$10,000[2]	Unlimited	$7,500/$7,500/$15,000[2]	Unlimited	$3,000/$6,000/$6,000
Annual Combined Medical Deductible and Prescription Drug Deductible - Plan deductible applies unless otherwise stated							
Individual/Individual in Family/Family	$1,500/$3,000/$3,000	$4,000/$8,000/$8,000	$1,600/$3,000/$3,200[2]	$4,500/$4,500/$9,000[2]	$3,000/$3,000/$6,000[2]	$5,000/$5,000/$10,000[2]	$1,500/$3,000/$3,000
Plan Information							
Type of Plan	Preferred Provider Organiztion (PPO)		Preferred Provider Organiztion (PPO)		Preferred Provider Organiztion (PPO)		Health Maintenance Organization (HMO)
Referrals Required?	No		No		No		Yes
Plan Coinsurance	Plan Pays 90% (After Deductible)	Plan Pays 50% (After Deductible)	Plan Pays 80% (After Deductible)	Plan Pays 50% (After Deductible)	Plan Pays 60% (After Deductible)	Plan Pays 50% (After Deductible)	Plan Pays 90% (After Deductible)
Health Savings Account (HSA) Compatibility							
HSA-Compatible Plan:	Yes		Yes		Yes		Yes
2023 Individual Maximum Contribution:	$3,850		$3,850		$3,850		$3,850
2023 Family Maximum Contribution:	$7,750		$7,750		$7,750		$7,750
Over 55 HSA Contribution Catch-Up:	$1,000		$1,000		$1,000		$1,000
Physician/Diagnostic Services							
Preventive Care	$0 (Deductible Waived)	50% Coinsurance (After Deductible)	$0 (Deductible Waived)	50% Coinsurance (After Deductible)	$0 (Deductible Waived)	50% Coinsurance (After Deductible)	$0 (Deductible Waived)
Primary Care Office Visit	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$45 Copay (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)
Specialist Office Visit	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$45 Copay (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)	40% 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	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $800 per procedure maximum	10% Coinsurance (After Deductible)
Inpatient Hospital Services							
Inpatient Hospitalization	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $1,000 maximum per day	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $1,000 maximum per day	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $1,000 maximum per day	10% Coinsurance (After Deductible)
Outpatient Services							
Outpatient Surgery	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $350 maximum	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $350 maximum	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $350 maximum	10% Coinsurance (After Deductible)
Outpatient Lab and Imaging	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $350 maximum	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $350 maximum	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $350 maximum	10% Coinsurance (After Deductible)
Emergency Services							
Ambulance Services	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		40% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)
Emergency Room	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		40% Coinsurance (After Deductible; $250 Copay, Waived if Admitted)		10% Coinsurance (After Deductible)
Urgent Care							
Urgent Care Visits	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$45 Copay (After Deductible)	50% 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]For Anthem CDHP PPO 80 & CDHP PPO 60: The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and 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 deductible or per person out-of-pocket maximum.

CSEBO MEDICAL INSURANCE
CONSUMER-DIRECTED HEALTH PLANS (CDHP) COMPARISON
EFFECTIVE 1/1/2023 - 12/31/2023

Anthem Blue Cross

KAISER PERMANENTE®

PLAN NUMBER	ANTHEM BLUE CROSS						KAISER PERMANENTE
	CDHP PPO 90		CDHP PPO 80		CDHP PPO 60		CDHP DHMO $1,500
GENERAL PLAN INFORMATION	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK ONLY
Mental Health and Substance Abuse							
Inpatient Mental Health	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $1,000 maximum	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $1,000 maximum	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $1,000 maximum	10% Coinsurance (After Deductible)
Outpatient Mental Health Office Visit	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$45 Copay (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)	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)
Other Practicioner Visits							
Acupunture	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%	20% 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%	40% 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), 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%	20% 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%	40% 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	Combined with Medical		Combined with Medical		Combined with Medical		Combined with Medical
Prescription Drug Deductible							
Individual/Individual in Family/Family	Combined with Medical		Combined with Medical		Combined with Medical		Combined with Medical
Prescription Drug Formulary							
Formulary (Covered Drugs)	National 4-Tier		National 4-Tier		National 4-Tier		CA Commercial 3-Tier
Retail	**30-Day Supply**		**30-Day Supply**		**30-Day Supply**		**30-Day Supply**
Generic	$10 Copay (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible; Not to Exceed $250)	50% Coinsurance (After Deductible)	$20 Copay (After Deductible)	50% Coinsurance (After Deductible)	$10 Copay (After Deductible)
Brand (Formulary/Preferred)	$30 Copay (After Deductible)				$45 Copay (After Deductible)		$30 Copay (After Deductible)
Brand (Non-Formulary/Non-Preferred)	$30 Copay (After Deductible)				$60 Copay (After Deductible)		$30 Copay (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	20% Coinsurance(After Deductible; Not to Exceed $150)				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	$20 Copay (After Deductible)	Paper claim submission required	20% Coinsurance (After Deductible; Not to Exceed $250)	Paper claim submission required	$40 Copay (After Deductible)	Paper claim submission required	$20 Copay (After Deductible)
Brand (Formulary/Preferred)	$60 Copay (After Deductible)				$90 Copay (After Deductible)		$60 Copay (After Deductible)
Brand (Non-Formulary/Preferred)	$60 Copay (After Deductible)				$120 Copay (After Deductible)		$60 Copay (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	20% (After Deductible; Not to Exceed $150)				20% (After Deductible; Not to Exceed $150)		20% Coinsurance (After Deductible; Not to Exceed $150)

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 EOC, the EOC will prevail.

CSEBO