CSEBO MEDICAL INSURANCE
PROPOSED HMO COMPARISON
EFFECTIVE 1/1/2024 - 12/31/2024

PLAN NUMBER	ANTHEM BLUE CROSS		KAISER PERMANENTE	
GENERAL PLAN INFORMATION	HMO 10 IN-NETWORK ONLY	HMO 30 IN-NETWORK ONLY	HMO 10 IN-NETWORK ONLY	HMO 30 IN-NETWORK ONLY
Annual Medical and Prescription Drug Combined Out-of-Pocket Limit[1]				
Individual/Individual in Family/Family	$1,500/$1,500/$4,500	$5,000/$5,000/$10,000	$1,500/$1,500/$3,000	$1,500/$1,500/$3,000
Annual Medical Deductible				
Individual/Family	$0	$0	$0	$0
Physician/Diagnostic Services				
Preventive Care	$0	$0	$0	$0
TeleMedicine (Audio/Video Visits)	$0	$0	$0	$0
Primary Care Office Visit	$10 Copay	$30 Copay	$10 Copay	$30 Copay
Specialist Office Visit	$10 Copay	$40 Copay	$10 Copay	$30 Copay
Diagnostic X-Ray and Lab Tests	$0	$0	$0	$0
Advanced Imaging	$0	$100 Copay per Test	$0	$0
Inpatient Hospital Services				
Inpatient Hospitalization	$0	30% Coinsurance	$0	$0
Outpatient Services				
Outpatient Surgery	$0	30% Coinsurance	$10 Copay per Procedure	$30 Copay per Procedure
Outpatient Lab and Imaging	$0	30% Coinsurance	$0	$0
Emergency Services				
Ambulance Services	$0	$100 per trip	$50 per trip	$50 per trip
Emergency Room	$50 Copay (Waived if Admitted)	$200 Copay (Waived if Admitted)	$50 Copay (Waived if Admitted)	$50 Copay (Waived if Admitted)
Urgent Care				
Urgent Care Visits	$10 Copay	$30 Copay	$10 Copay	$30 Copay

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

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PLAN NUMBER	ANTHEM BLUE CROSS		KAISER PERMANENTE	
GENERAL PLAN INFORMATION	HMO 10 IN-NETWORK ONLY	HMO 30 IN-NETWORK ONLY	HMO 10 IN-NETWORK ONLY	HMO 30 IN-NETWORK ONLY
Mental Health and Substance Abuse				
Inpatient Mental Health	$0	30% Coinsurance	$0	$0
Outpatient Mental Health Office Visit	$10 Copay	$30 Copay	$10 Copay	$30 Copay
Other Outpatient Mental Health Services	$0	30% Coinsurance	$0	$0
Other Services				
Hearing Aids	One per Ear, Every 36 Months	Not Covered	Not Covered	Not Covered
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**	**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				
Per Individual	$0	$0	$0	$0
Prescription Drug Formulary				
Formulary (Covered Drugs)	National 3-Tier	National 4-Tier	CA Commercial 2-Tier	CA Commercial 3-Tier
Retail	**30-Day Supply**	**30-Day Supply**	**30-Day Supply**	**30-Day Supply**
Generic	$10 Copay	$15 Copay	$10 Copay	$15 Copay
Brand (Formulary/Preferred)	$20 Copay	$30 Copay	$20 Copay	$30 Copay
Brand (Non-Formulary/Non-Preferred)	$20 Copay	$50 Copay	$20 Copay	$30 Copay
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	$20 Copay	30% Coinsurance (Not to Exceed $150)	$20 Copay	50% Coinsurance (Not to Exceed $200)
Mail Order	**90-Day Supply**	**90-Day Supply**	**100-Day Supply**	**100-Day Supply**
Generic	$20 Copay	$15 Copay	$10 Copay	$30 Copay
Brand (Formulary/Preferred)	$40 Copay	$60 Copay	$20 Copay	$60 Copay
Brand (Non-Formulary/Non-Preferred)	$40 Copay	$100 Copay	$20 Copay	$60 Copay
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	$40 Copay	30% Coinsurance (Not to Exceed $300)	Retail Only	Retail Only

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.