CSEBO MEDICAL INSURANCE
HEALTH PLAN COMPARISON
DISTRICT-PAID RETIREES (OVER 65)
EFFECTIVE 1/1/2024 – 12/31/2024

CARRIER PLAN NAME GENERAL PLAN INFORMATION	ANTHEM BLUE CROSS INDEMNITY II PPO IN-NETWORK	 OUT-OF-NETWORK[1]	KAISER PERMANENTE KPSA $0 COPAY IN-NETWORK ONLY
Annual Medical Out-of-Pocket Limit			
Individual/Individual in Family/Family	$5,000 per Person[2]	Unlimited	$1,500/$1,500/$3,000[3]
Annual Medical Deductible - Plan Deductible Applies Unless Otherwise Stated			
Individual/Individual in Family/Family	$100/$100/$300[2]	$100/$100/$300[2]	$0
Plan Information			
Type of Plan	Preferred Provider Organization (PPO)		Health Maintenace Organization (HMO)
Referrals Required?	No		Yes
Plan Coinsurance	Plan Pays 80% (After Deductible)	Plan Pays 80% (After Deductible)	N/A
Medicare Compatibility:			
Medicare Coordination:	Medicare pays primary to this Coordination of Benefits (COB) plan. For members who are entitled to Medicare Part A and enrolled in Medicare Part B.		Medicare Advantage Plan
Physician/Diagnostic Services			
Preventive Care	No Charge	Not Covered	No Charge
Primary Care Office Visit	20% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	No Charge
Specialist Office Visit	20% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	No Charge
Diagnostic X-Ray and Lab Tests	20% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	No Charge
Advanced Imaging (MRI/PET/CAT Scans)	20% Coinsurance (After Deductible)	20% Coinsurance (After Deductible) up to $800 per Procedure Maximum	No Charge
Inpatient Hospital Services			
Inpatient Hospitalization	0%[4] Coinsruance (After Deductible)	20% Coinsurance (After Deductible)[4] up to $1,000 Maximum per Day	No Charge
Outpatient Services			
Outpatient Surgery	0%[4] Coinsurance (After Deductible)	20% Coinsurance (After Deductible)[4] up to $350 per Day Maximum	No Charge
Outpatient Lab and Imaging	20%[4] Coinsurance (After Deductible)	20% Coinsurance (After Deductible)[4] up to $350 per Procedure Maximum	No Charge
Emergency Services			
Ambulance Services	0% Coinsurance (After Deductible)		No Charge
Emergency Room	0% Coinsurance (After Deductible)		No Charge
Urgent Care			
Urgent Care Visits	20% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	No Charge

[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 Indemnity IV PPO: 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 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.

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

To access the Uniform Glossary of Health Coverage and Medical Terms, please visit: http://www.csebo.net/Resources/Uniform-Glossary.

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Anthem

KAISER PERMANENTE®

CARRIER PLAN NAME	ANTHEM BLUE CROSS INDEMNITY II PPO		KAISER PERMANENTE KPSA $0 COPAY
Mental Health and Substance Abuse	**In-Network**	**Out-of-Network**	**In-Network Only**
Inpatient Mental Health	0%[4] Coinsurance (After Deductible)	20%[4] Coinsurance (After Deductible) up to $1,000 per Day Maximum	No Charge
Outpatient Mental Health Office Visit	20% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	No Charge
Other Outpatient Health Services	20% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	No Charge
Other Services			
Acupuncture	20% Coinsurance (After Deductible), Maximum of 18 Visits per Calendar Year, Then Plan Pays 0%	20% Coinsurance (After Deductible)	$10 Copay, Combined 30 Visits per 12-Month Period for Acupuncure and Chiropractic Services, Referral Not Required
Chiropractor Services	$10 Copay (Deductible Waived), Maximum of 45 Visits per Calendar Year, Then Plan Pays 0%	20% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	$10 Copay, Combined 30 Visits per 12-Month Period for Acupuncure and Chiropractic Services, Referral Not Required
Hearing Aids	$500 Maximum Benefit per Ear, Every 12 Months		No Coverage
Infertility Diagnosis & Treatment	$20K Lifetime Maximum, 50% Coinsurance		No Charge, $0 Inpatient, $0 Lab, Imaging, & Special Encounter
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK ONLY**
Annual Prescription Drug Out-of-Pocket Limit			
Individual/Individual in Family/Family	Combined with Medical	Unlimited	Combined with Medical
Prescription Drug Deductible			
Per Individual	$0		$0
Prescription Drug Formulary			
Fomulary (Covered Drugs)	National 3-Tier		Medicare Part D Formulary
Retail	**30-Day Supply**		**100-Day Supply**
Generic	$8 Copay (Deductible Waived), or 20% Coinsurance, Whichever Greater	Paper Claim Submission Required	$5 Copay
Brand (Formulary/Preferred)	$15 Copay (Deductible Waived), or 20% Coinsurance, Whichever Greater		$5 Copay
Brand (Non-Formulary/Non-Preferred)	$25 Copay (Deductible Waived), or 25% Coinsurance, Whichever Greater		$5 Copay
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	Same as Retail Brand		$5 Copay
Mail Order	**90-Day Supply**		**100-Day Supply**
Generic	$10 Copay (Deductible Waived)	Paper Claim Submission Required	$5 Copay
Brand (Formulary/Preferred)	$20 Copay (Deductible Waived)		$5 Copay
Brand (Non-Formulary/Non-Preferred)	$35 Copay (Deductible Waived)		$5 Copay
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	$35 Copay (Deductible Waived)		$5 Copay

[2]For Anthem Indemnity IV PPO: 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.

Ventura Unified SCHOOL DISTRICT

CSEBO