CSEBO MEDICAL INSURANCE
CONSUMER-DIRECTED HEALTH PLANS (CDHP) COMPARISON
EFFECTIVE 1/1/2025 - 12/31/2025

Anthem

KAISER PERMANENTE®

PLAN NUMBER	ANTHEM BLUE CROSS						KAISER PERMANENTE	
	CDHP PPO 90		CDHP PPO 80		CDHP PPO 60		CDHP DHMO 90	CDHP DHMO 60
GENERAL PLAN INFORMATION	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK ONLY	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	$8,300/$8,300/$16,600[2]	Unlimited	$3,300/$3,300/$6,600[3]	$6,250/$6,250/$12,500[2]
Annual Combined Medical Deductible and Prescription Drug Deductible - Plan deductible applies unless otherwise stated								
Individual/Individual in Family/Family	$1,650/$3,300/$3,300	$4,000/$8,000/$8,000	$1,750/$3,300/$3,500[2]	$4,500/$4,500/$9,000[2]	$3,300/$3,300/$6,600[2]	$5,000/$5,000/$10,000[2]	$1,650/$3,300/$3,300[2]	$4,500/$4,500/$9,000[2]
Plan Information								
Type of Plan	Preferred Provider Organiztion (PPO)		Preferred Provider Organiztion (PPO)		Preferred Provider Organiztion (PPO)		Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Referrals Required?	No		No		No		Yes	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)	Plan Pays 60% (After Deductible)
Health Savings Account (HSA) Compatibility								
HSA-Compatible Plan:	Yes		Yes		Yes		Yes	Yes
2025 Individual Maximum Contribution:	$4,300		$4,300		$4,300		$4,300	$4,300
2025 Family Maximum Contribution:	$8,550		$8,550		$8,550		$8,550	$8,550
Over 55 HSA Contribution Catch-Up:	$1,000		$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)	$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)	$40 Copay (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)	$40 Copay (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)	40% 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)	40% Coinsurance (After Deductible; Not to Exceed $150 per Procedure)
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)	40% 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)	40% 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)	40% Coinsurance (After Deductible)
Emergency Services								
Ambulance Services	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		40% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)	40% 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)	40% Coinsurance (After Deductible; $250 Copay, Waived if Admitted)

[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 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.

[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.

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GENERAL PLAN INFORMATION	**IN-NETWORK**	**OUT-OF-NETWORK[1]**	**IN-NETWORK**	**OUT-OF-NETWORK[1]**	**IN-NETWORK**	**OUT-OF-NETWORK[1]**	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**
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)	$40 Copay (After Deductible)
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)	40% 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)	$40 Copay (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)	40% Coinsurance (After Deductible)
Other Services								
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	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	N/A
Hearing Aids	$500 Maximum Benefit per Ear, Every 12 Months		$500 Maximum Benefit per Ear, Every 12 Months		$500 Maximum Benefit per Ear, Every 12 Months		N/A	N/A
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**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	Combined with Medical
Prescription Drug Deductible								
Individual/Individual in Family/Family	Combined with Medical		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	CA Commercial 3-Tier
Retail	**30-Day Supply**		**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)	$15 Copay (After Deductible)
Brand (Formulary/Preferred)	$30 Copay (After Deductible)				$45 Copay (After Deductible)		$30 Copay (After Deductible)	$35 Copay (After Deductible)
Brand (Non-Formulary/Non-Preferred)	$30 Copay (After Deductible)				$60 Copay (After Deductible)		$30 Copay (After Deductible)	$35 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)	30% Coinsurance (After Deductible; Not to Exceed $250)
Mail Order	**90-Day Supply**		**90-Day Supply**		**90-Day Supply**		**100-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)	$30 Copay (After Deductible)
Brand (Formulary/Preferred)	$60 Copay (After Deductible)				$90 Copay (After Deductible)		$60 Copay (After Deductible)	$70 Copay (After Deductible)
Brand (Non-Formulary/Preferred)	$60 Copay (After Deductible)				$120 Copay (After Deductible)		$60 Copay (After Deductible)	$70 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)	30% Coinsurance (After Deductible; Not to Exceed $250)

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.

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