



CARRIER CDHP PPO 80 CDHP PPO 8			ANTHEM BI	KAISER PERMANENTE		
Camera   C		CDHP				
Annual Medical Out-of-Pocket Limits   Individual/Individual in Family/Family   \$3,000/56,000   Unlimited   \$5,000/\$5,000/\$10,000   Unlimited   \$3,200/\$3,200/\$6,400   S4,000/\$6,000   S4,000/\$6,000   S1,000/\$5,000/\$10,000   S4,000/\$5,000   S4,000   S4,		IN-NETWORK	OUT-OF-NETWORK <sup>1</sup>	IN-NETWORK	OUT-OF-NETWORK <sup>1</sup>	IN-NETWORK ONLY
Annual Medical Deductible - Plan Deductible - Plan Deductible   S3,000/\$6,000   S1,000/\$6,000   S1,000/\$6,00						
Annual Medical Deductible - Plan Deductible   Policy   S1,600/\$3,200/\$3,200   \$4,000/\$8,000   \$1,700/\$3,200/\$3,400   \$4,500/\$4,500/\$9,000   \$1,600/\$53,200/\$3,200   \$1,600/\$53,200/\$3,200   \$1,600/\$53,200/\$53,200/\$53,200   \$1,600/\$53,200/\$53,	•	\$3.000/\$6.000/\$6.000	Unlimited	\$5,000/\$5,000/\$10,000 <sup>2</sup>	Unlimited	\$3,200/\$3,200/\$6,400 <sup>2</sup>
Individual/Individual in Family/Family				\$3,000,\$3,000,\$10,000		φο/200/ φο/200/ φο/ 100
Plan Information  Type of Plan Preferred Provider Organization (PPO) Prudent Buyer PPO Plan Coinsurance Plan Pays 90% (After Deductible) Plan Pays 50% Coinsurance (After Deductible) Plan Pays 50% Coinsurance (After Deductible) Plan Pays 50% Coinsurance (After Deductible) Plan Pays 50% (After Dedu	· ·	• •		\$1.700/\$3.200/\$3.400 <sup>2</sup>	\$4 500/\$4 500/\$9 0002	\$1 600/\$3 200/\$3 200 <sup>2</sup>
Type of Plan Your Network Referrals Required? Referrals Required? Plan Coinsurance Plan Coinsurance Plan Coinsurance Plan Coinsurance Plan Coinsurance Plan Pays 50% (After Deductible) Plan Pays 50% Coinsurance (After Deductible) Plan Pays 50% Coinsurance (After Deductible) Plan Pays 80% (After Deductible) Plan Pays 90% (After De		+-,, +-,	+ 1,000,40,000,40,000	\$1,700/\$3,200/\$3,400	\$4,500/\$4,500/\$5,000	ψ1,000, ψ0,200, ψ0,200
Referrals Required? Referrals Required? Plan Coinsurance Plan Pays 90% (After Deductible) Plan Pays 50% Coinsurance (After Deductible) Plan Pays 80% (After Deductible) Plan Pays 80% (After Deductible) Plan Pays 80% (After Deductible)  Flan Pays 90% (After Deductible)  Flan Pays 90% (After Deductible)  Flan Pays 80% (After Deductible)  Flan Pays		Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Health Maintenance Organization (HMO)
Plan Pays 90% (After Deductible) Plan Pays 80% (After Deductible)	"	- · · · ·		Prudent	Buyer PPO	Kaiser HMO Network
Plan Pays 90% (After Deductible)   Some Coinsurance (After Deductible)   Some		· ·			No	Yes
Health Savings Account (HSA) Compatibility:  HSA-Compatible Plan? 2025 Individual Maximum Contribution 34,300 2025 Family Maximum Contribution Over 55 HSA Contribution Catch-Up Physician/ Diagnostic Services  Preventive Care Primary Care Office Visit Diagnostic V-Ray and Lab Tests Advanced Imaging (MRI/PET/CAT Scans) Inpatient Hospitalization Impatient Hospitalization Inpatient Hospitalization Inpatient Hospitalization  HSA-Compatibility:  Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye	·	Plan Pays 90% (After Deductible)	, ,	Plan Pays 80% (After Deductible)	,	Plan Pays 90% (After Deductible)
HSA-Compatible Plan? 2025 Individual Maximum Contribution 2025 Family Maximum Contribution Over 55 HSA Contribution Catch-Up Physician/ Diagnostic Services  Preventive Care Primary Care Office Visit Specialist Office Visit Diagnostic X-Ray and Lab Tests Advanced Imaging (MRI/PET/CAT Scans) Inpatient Hospitalization Inpatient Hospitalization Inpatient Hospitalization Inpatient Hospitalization  Pess, 550 Ses, 50 Ses, 550 Ses		, , ,	Deductible)	, , ,	Deductible)	<u> </u>
2025 Individual Maximum Contribution 2025 Family Maximum Contribution 58,550 59,550 58,550 59,550 59,550 59,550 59,550 59,550 59,550 59,550 59,550 59,550 59,550 59,550 59,550 59				,	/	Vee
2025 Family Maximum Contribution Over 55 HSA Contribution Catch-Up  Physician/Diagnostic Services  Primary Care Office Visit Specialist Office Visit Diagnostic X-Ray and Lab Tests Advanced Imaging (MRI/PET/CAT Scans) Inpatient Hospital Services  Services  No Coinsurance (After Deductible) Services  No Coinsurance (After Deductible) Some Coinsurance (Af	' '					
Over 55 HSA Contribution Catch-Up  Physician/Diagnostic Services  Preventive Care Primary Care Office Visit Specialist Office Visit Diagnostic X-Ray and Lab Tests Advanced Imaging (MRI/PET/CAT Scans) Inpatient Hospitalization Preventive Care Inpatient Hospitalization Primary Care Office Visit Primary Care Office Visit Overed Sow Coinsurance (After Deductible) Specialist Office Visit Deductible Sow Coinsurance (After Deductible) Deductible Deductib						• •
Physician/Diagnostic Services  Preventive Care Primary Care Office Visit Poductible)  Specialist Office Visit Diagnostic X-Ray and Lab Tests Advanced Imaging (MRI/PET/CAT Scans)  Inpatient Hospital Services  Proventive Care Primary Care Office Visit Poductible)  Inpatient Hospital Services  No Charge Not Covered No Charge 20% Coinsurance (After Deductible)  No Charge Sow Coinsurance (After Deductible)  De	,					
Preventive Care Primary Care Office Visit Poductible)  Specialist Office Visit Deductible)  Specialist Office Visit Deductible)  Diagnostic X-Ray and Lab Tests Poductible)  Advanced Imaging (MRI/PET/CAT Scans)  Inpatient Hospital Services  No Charge Not Covered Sow Coinsurance (After Deductible)  Sow Coinsurance (After Deductible)  Deductible)  Deductible)  Sow Coinsurance (After Deductible)  Deductible)  Deductible)  Deductible)  Deductible)  Deductible)  Sow Coinsurance (After Deductible)  De	• •	\$1,	000	\$1	,000	\$1,000
Primary Care Office Visit Specialist Office Visit Diagnostic X-Ray and Lab Tests Advanced Imaging (MRI/PET/CAT Scans) Inpatient Hospital Services  10% Coinsurance (After Deductible) 10% Coinsurance (After Deductible) 50% Coins		No Channa	l Not Coursed	No Charac	Not Coursed	No Charge
Primary Care Office Visit  Specialist Office Visit  Diagnostic X-Ray and Lab Tests  Advanced Imaging (MRI/PET/CAT Scans)  Inpatient Hospital Services  Deductible)  Deductible	Preventive Care	-				No Charge
Deductible   Ded	Primary Care Office Visit	Deductible)	Deductible)	Deductible)	Deductible)	10% Coinsurance (After Deductible)
Deductible)  Advanced Imaging (MRI/PET/CAT Scans)  Inpatient Hospital Services  Inpatient Hospitalization  Inpatient Hospitalizat	Specialist Office Visit	·	· ·	· · · · · · · · · · · · · · · · · · ·	,	10% Coinsurance (After Deductible)
Advanced Imaging (MRI/PET/CAT Scans)  Inpatient Hospital Services  Inpatient Hospitalization  Inpatien	Piagnostic X-Ray and Lab Tests	· · · · · · · · · · · · · · · · · · ·	Deductible)	· · · · · · · · · · · · · · · · · · ·	Deductible)	10% Coinsurance (After Deductible)
Inpatient Hospital Services  Inpatient Hospitalization Inpatient Hospitalization Deductible)  10% Coinsurance (After Deductible) up to \$1,000 maximum per day  20% Coinsurance (After Deductible) up to \$1,000 maximum per day  20% Coinsurance (After Deductible) up to \$1,000 maximum per day  10% Coinsurance (After Deductible) maximum per day	Imaging (MRI/PET/CAT Scans)	,	Deductible) up to \$800 per	,	Deductible) up to \$800 per	10% Coinsurance (After Deductible)
Inpatient Hospitalization Deductible)  10% Coinsurance (After Deductible) up to \$1,000 maximum per day  20% Coinsurance (After Deductible) up to \$1,000 maximum per day  20% Coinsurance (After Deductible) up to \$1,000 maximum per day  10% Coinsurance (After Deductible) up to \$1,000 maximum per day	pital Services					
Outpatient Services	Inpatient Hospitalization	•	Deductible) up to \$1,000	,	Deductible) up to \$1,000	10% Coinsurance (After Deductible)
	rvices					
Outpatient Surgery Deductible)  10% Coinsurance (After Deductible) up to \$350 maximum Deductible)  20% Coinsurance (After Deductible) Deductible) Deductible) up to \$350 maximum Deductible)  20% Coinsurance (After Deductible) Deductible) up to \$350 maximum Deductible)	Outpatient Surgery	•	,	,	,	10% Coinsurance (After Deductible)
Outpatient Lab and Imaging  10% Coinsurance (After Deductible)  10% Coinsurance (After Deductible) up to \$350 maximum  20% Coinsurance (After Deductible)  50% Coinsurance (After Deductible)  10% Coinsurance (After Deductible)  10% Coinsurance (After Deductible)	Outpatient Lab and Imaging	,	· ·		,	10% Coinsurance (After Deductible)
Emergency Services	rvices					
Ambulance Services 10% Coinsurance (After Deductible) 20% Coinsurance (After Deductible) 10% Coinsurance (After Deductible)	Ambulance Services	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)
Emergency Room 10% Coinsurance (After Deductible) 20% Coinsurance (After Deductible) 10% Coinsurance (After Deductible)	Emergency Room	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)
Urgent Care						
Urgent Care Visits  10% Coinsurance (After Deductible)  10% Coinsurance (After Deductible)  Deductible)  Deductible)  Deductible)  10% Coinsurance (After Deductible)  Deductible)  Deductible)	Urgent Care Visits	•	•	,	,	10% Coinsurance (After Deductible)

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





<sup>&</sup>lt;sup>2</sup>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.





CARRIER		ANTHEM BI	KAISER PERMANENTE		
PLAN NAME	CDHP	PPO 90	CDHP PPO 80		CDHP DHMO 90
Mental Health and Substance Abuse	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
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	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)	10% Coinsurance (After Deductible)
Other Outpatient Health Services	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)
Other Services					
Acupuncture	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%	Not Covered
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%	Not Covered
Hearing Aids	\$500 Maximum Benefit ¡	oer Ear, Every 12 Months	\$500 Maximum Benefit	per Ear, Every 12 Months	Not Covered
Infertility Diagnosis & Treatment	\$20K Lifetime Maximum, 50% Coinsurance		\$20K Lifetime Maximum, 50% Coinsurance		Not Covered
PRESCRIPTION DRUG BENEFITS	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
Annual Prescription Drug Out-of-Pocket Lir					
Individual/Individual in Family/Family	Combined with Medical		Combined with Medical		Combined with Medical
Prescription Drug Deductible  Per Individual	Combined with Medical		Combined with Medical		Combined with Medical
Prescription Drug Formulary					
Fomulary (Covered Drugs)	National 4-Tier		National 4-Tier		<u>CA Commercial 3-Tier</u>
Retail	30-Day Supply		30-Day Supply		30-Day Supply
Generic	\$10 Copay (After Deductible)				\$10 Copay (After Deductible)
Brand (Formulary/Preferred) Brand (Non-Formulary/Non-Preferred)	\$30 Copay (After Deductible) \$30 Copay (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible; Not to Exceed \$250)	50% Coinsurance (After Deductible)	\$30 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)
Mail Order	90-Day Supply		90-Day Supply		100-Day Supply
Generic	\$20 Copay (After Deductible)				\$20 Copay (After Deductible)
Brand (Formulary/Preferred) Brand (Non-Formulary/Non-Preferred) Specialty Rx (Specialty Pharmacy Only; 30- day supply)	\$60 Copay (After Deductible) \$60 Copay (After Deductible) 20% (After Deductible; Not to Exceed \$150)	Paper Claim Submission Required	20% Coinsurance (After Deductible; Not to Exceed \$250)	Paper Claim Submission Required	\$60 Copay (After Deductible) \$60 Copay (After Deductible) 20% Coinsurance (After Deductible; Not to Exceed \$150)

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.

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





<sup>5\$250</sup> 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), will prevail.