CSEBO MEDICAL INSURANCE
CDHP HEALTH PLAN COMPARISON – OSSA
EFFECTIVE 1/1/2025 – 12/31/2025

CARRIER	ANTHEM BLUE CROSS				KAISER PERMANENTE
PLAN NAME	CDHP PPO 90		CDHP PPO 80		CDHP DHMO 90
GENERAL PLAN INFORMATION	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK ONLY
Annual Medical Out-of-Pocket Limit					
Individual/Individual in Family/Family	$3,000/$6,000/$6,000	Unlimited	$5,000/$5,000/$10,000[2]	Unlimited	$3,200/$3,200/$6,400[2]
Annual Medical Deductible - Plan Deductible Applies Unless Otherwise Stated					
Individual/Individual in Family/Family	$1,600/$3,200/$3,200	$4,000/$8,000/$8,000	$1,700/$3,200/$3,400[2]	$4,500/$4,500/$9,000[2]	$1,600/$3,200/$3,200[2]
Plan Information					
Type of Plan	Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Health Maintenance Organization (HMO)
Your Network	Prudent Buyer PPO		Prudent Buyer PPO		Kaiser HMO Network
Referrals Required?	No		No		Yes
Plan Coinsurance	Plan Pays 90% (After Deductible)	Plan Pays 50% Coinsurance (After Deductible)	Plan Pays 80% (After Deductible)	50% Coinsurance (After Deductible)	Plan Pays 90% (After Deductible)
Health Savings Account (HSA) Compatibility:					
HSA-Compatible Plan?	Yes		Yes		Yes
2025 Individual Maximum Contribution	$4,300		$4,300		$4,300
2025 Family Maximum Contribution	$8,550		$8,550		$8,550
Over 55 HSA Contribution Catch-Up	$1,000		$1,000		$1,000
Physician/Diagnostic Services					
Preventive Care	No Charge	Not Covered	No Charge	Not Covered	No Charge
Primary Care Office Visit	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (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)	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)	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	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	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	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	10% Coinsurance (After Deductible)
Emergency Services					
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)
Urgent Care					
Urgent Care Visits	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (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]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.

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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 per 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 Limit					
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		CA Commercial 3-Tier
Retail	**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)	$10 Copay (After Deductible)
Brand (Formulary/Preferred)	$30 Copay (After Deductible)				$30 Copay (After Deductible)
Brand (Non-Formulary/Non-Preferred)	$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)	Paper Claim Submission Required	20% Coinsurance (After Deductible; Not to Exceed $250)	Paper Claim Submission Required	$20 Copay (After Deductible)
Brand (Formulary/Preferred)	$60 Copay (After Deductible)				$60 Copay (After Deductible)
Brand (Non-Formulary/Non-Preferred)	$60 Copay (After Deductible)				$60 Copay (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	20% (After Deductible; Not to Exceed $150)				20% Coinsurance (After Deductible; Not to Exceed $150)

[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.

[5]$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.

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