

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



PLAN NUMBER		ANTHEM BLUE CROSS		KAISER PERMANENTE	
		HMO 30	HMO 30 - SELECT NETWORK	HMO 30	
GENERAL PLAN INFORMATION		IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK ONLY	
Annual Medical and Prescription Drug Combined Out-of-Pocket Limit¹					
Individual/Individual in Family/Family		\$5,000/\$5,000/\$10,000	\$5,000/\$5,000/\$10,000	\$1,500/\$1,500/\$3,000	
Annual Medical Deductible					
Individual/Individual in Family/Family		\$0	\$0	\$0	
Plan Information					
Type of Plan	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)	
Your Network	CA Care HMO	Select HMO		Kaiser HMO	
Referrals Required?	Yes	Yes		Yes	
Physician/Diagnostic Services					
Preventive Care	No Charge	No Charge	No Charge	No Charge	
TeleMedicine (Audio/Video Visits)	No Charge	No Charge	No Charge	No Charge	
Primary Care Office Visit	\$30 Copay	\$30 Copay	\$30 Copay	\$30 Copay	
Specialist Office Visit	\$40 Copay	\$40 Copay	\$40 Copay	\$30 Copay	
Diagnostic X-Ray and Lab Tests	No Charge	No Charge	No Charge	No Charge	
Advanced Imaging	\$100 Copay per Test	\$100 Copay per Test	\$100 Copay per Test	No Charge	
Inpatient Hospital Services					
Inpatient Hospitalization	30% Coinsurance	30% Coinsurance	30% Coinsurance	No Charge	
Outpatient Services					
Outpatient Surgery	30% Coinsurance	30% Coinsurance	30% Coinsurance	\$30 Copay per Procedure	
Outpatient Lab and Imaging	30% Coinsurance	30% Coinsurance	30% Coinsurance	No Charge	
Emergency Services					
Ambulance Services	\$100 per Trip	\$100 per Trip	\$100 per Trip	\$50 per Trip	
Emergency Room	\$200 Copay (Waived if Admitted)	\$200 Copay (Waived if Admitted)	\$200 Copay (Waived if Admitted)	\$50 Copay (Waived if Admitted)	

¹The 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.





PLAN NUMBER		ANTHEM BLUE CROSS		KAISER PERMANENTE	
GENERAL PLAN INFORMATION		HMO 30 IN-NETWORK ONLY	HMO 30 - SELECT NETWORK IN-NETWORK ONLY	HMO 30 IN-NETWORK ONLY	
Urgent Care					
Urgent Care Visits		\$30 Copay	\$30 Copay	\$30 Copay	
Mental Health and Substance Abuse					
Inpatient Mental Health		30% Coinsurance	30% Coinsurance	No Charge	
Outpatient Mental Health Office Visit		\$30 Copay	\$30 Copay	\$30 Copay	
Other Outpatient Mental Health Services		30% Coinsurance	30% Coinsurance	No Charge	
Other Services					
Hearing Aids		Not Covered	Not Covered	Not Covered	
PRESCRIPTION DRUG BENEFITS		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	
Prescription Drug Deductible					
Per Individual		\$0	\$0	\$0	
Prescription Drug Formulary					
Formulary (Covered Drugs)		National 4-Tier	National 4-Tier	CA Commercial 3-Tier	
Retail		30-Day Supply	30-Day Supply	30-Day Supply	
Generic		\$15 Copay	\$15 Copay	\$15 Copay	
Brand (Formulary/Preferred)		\$30 Copay	\$30 Copay	\$30 Copay	
Brand (Non-Formulary/Non-Preferred)		\$50 Copay	\$50 Copay	\$30 Copay	
Specialty Rx (Specialty Pharmacy Only; 30-day supply)		30% Coinsurance (Not to Exceed \$150)	30% Coinsurance (Not to Exceed \$150)	50% Coinsurance (Not to Exceed \$200)	
Mail Order		90-Day Supply	90-Day Supply	100-Day Supply	
Generic		\$15 Copay	\$15 Copay	\$30 Copay	
Brand (Formulary/Preferred)		\$60 Copay	\$60 Copay	\$60 Copay	
Brand (Non-Formulary/Non-Preferred)		\$100 Copay	\$100 Copay	\$60 Copay	
Specialty Rx (Specialty Pharmacy Only; 30-day supply)		30% Coinsurance (Not to Exceed \$300)	30% Coinsurance (Not to Exceed \$300)	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.

