

CSEBO MEDICAL INSURANCE
TRADITIONAL PPO COMPARISON - OSSA
EFFECTIVE 1/1/2025 – 12/31/2025



CARRIER		ANTHEM BLUE CROSS					
PLAN NAME		INDEMNITY IV PPO		PPO 80		WELLNESS PPO	
GENERAL PLAN INFORMATION		IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹
Annual Medical Out-of-Pocket Limit							
Individual/Individual in Family/Family		\$2,000/\$2,000/\$4,000 ²	Unlimited	\$3,000/\$3,000/\$9,000 ²	Unlimited	\$5,000/\$5,000/\$12,700 ²	Unlimited
Annual Medical Deductible - Plan Deductible Applies Unless Otherwise Stated							
Individual/Individual in Family/Family		\$800/\$800/\$2,400 ²	\$800/\$800/\$2,400 ²	\$750/\$750/\$2,250 ²	\$1,500/\$1,500/\$4,500 ²	\$1,250/\$1,250/\$3,750 ^{2,3}	\$2,500/\$2,500/\$7,500 ^{2,3}
Plan Information							
Type of Plan		Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)	
Your Network		Prudent Buyer PPO		Select Network		Select Network	
Referrals Required?		No		No		No	
Plan Coinsurance		Plan Pays 85% (After Deductible)	Plan Pays 50% Coinsurance (After Deductible)	80% (After Deductible)	50% Coinsurance (After Deductible)	Plan Pays 70% (After Deductible)	Plan Pays 50% Coinsurance (After Deductible)
Health Savings Account (HSA) Compatibility:							
HSA-Compatible Plan?		No		No		No	
2025 Individual Maximum Contribution		N/A		N/A		N/A	
2025 Family Maximum Contribution		N/A		N/A		N/A	
Over 55 HSA Contribution Catch-Up		N/A		N/A		N/A	
Physician/Diagnostic Services							
Preventive Care		No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered
Primary Care Office Visit		15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)
Specialist Office Visit		15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	\$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$40 Copay (Deductible Waived)	50% Coinsurance (After Deductible)
Diagnostic X-Ray and Lab Tests		15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)
Advanced Imaging (MRI/PET/CAT Scans)		15% 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	30% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$800 per Procedure Maximum
Inpatient Hospital Services							
Inpatient Hospitalization		15% ⁵ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁵ up to \$1,000 Maximum per Day	20% ⁵ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁵ up to \$1,000 Maximum per Day	30% ⁵ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁵ up to \$1,000 Maximum per Day
Outpatient Services							
Outpatient Surgery		15% ⁵ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁵ up to \$350 per Day Maximum	30% ⁵ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁵ up to \$350 per Day Maximum	30% ⁵ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁵ up to \$350 per Day Maximum
Outpatient Lab and Imaging		15% ⁵ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁵ up to \$350 per Procedure Maximum	30% ⁵ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁵ up to \$350 per Procedure Maximum	30% ⁵ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁵ up to \$350 per Procedure Maximum
Emergency Services							
Ambulance Services		15% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		30% Coinsurance (After Deductible)	
Emergency Room		15% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		30% Coinsurance (After Deductible)	
Urgent Care							
Urgent Care Visits		15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)

¹When using out-of-network providers, you are responsible for the deductible, coinsurance, and additional amounts exceeding the usual and customary charges.

²The 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.

³A total of \$250 credits for each member in your family are available to lower your deductible. Please see supplementary plan documents for more information.

⁴The 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.

⁵\$250 deductible applies if utilization review is not obtained (waived for emergency admissions and outpatient freestanding surgery centers).



CARRIER		ANTHEM BLUE CROSS					
PLAN NAME	INDEMNITY IV PPO			PPO 80	WELLNESS PPO		
Mental Health and Substance Abuse	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Inpatient Mental Health	15% ⁵ Coinsurance (After Deductible)	50% ⁵ Coinsurance (After Deductible) up to \$1,000 per Day Maximum	20% ⁵ Coinsurance (After Deductible)	50% ⁵ Coinsurance (After Deductible) up to \$1,000 per Day Maximum	30% ⁵ Coinsurance (After Deductible)	50% ⁵ Coinsurance (After Deductible) up to \$1,000 per Day Maximum	
Outpatient Mental Health Office Visit	15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	
Other Outpatient Health Services	15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	
Other Services							
Acupuncture	15% Coinsurance (After Deductible), Maximum of 18 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	Not Covered	30% Coinsurance (After Deductible)	Not Covered	
Chiropractor Services	\$20 Copay (Deductible Waived), 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)	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	30% Coinsurance (After Deductible)	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	
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		
Infertility Diagnosis & Treatment	\$20K Lifetime Maximum, 50% Coinsurance		\$20K Lifetime Maximum, 50% Coinsurance		\$20K Lifetime Maximum, 50% Coinsurance		
PRESCRIPTION DRUG BENEFITS		IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Prescription Drug Out-of-Pocket Limit							
Individual/Individual in Family/Family	\$4,600/\$4,600/\$9,200 ²	Unlimited	\$2,000/\$2,000/\$4,000 ²	Unlimited	\$2,000/\$2,000/\$4,000 ²	Unlimited	
Prescription Drug Deductible							
Per Individual	\$0		\$0		\$0		
Prescription Drug Formulary							
Fomulary (Covered Drugs)	National 3-Tier		National 3-Tier		Essential 4-Tier		
Retail							
	30-Day Supply		30-Day Supply		30-Day Supply		
Generic	\$20 Copay (Deductible Waived)	Paper Claim Submission Required	\$10 Copay (Deductible Waived)	Paper Claim Submission Required	\$10 Copay (Deductible Waived)	Paper Claim Submission Required	
Brand (Formulary/Preferred)	\$30 Copay (Deductible Waived), or 20% Coinsurance, Whichever Greater		\$20 Copay (Deductible Waived)		\$20 Copay (Deductible Waived)		
Brand (Non-Formulary/Non-Preferred)	\$50 Copay (Deductible Waived), or 35% Coinsurance, Whichever Greater		\$35 Copay (Deductible Waived)		\$35 Copay (Deductible Waived)		
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	Same as Retail Brand		Same as Retail Brand		20% up to \$150 max copay (Deductible Waived)		
Mail Order							
	90-Day Supply		90-Day Supply		90-Day Supply		
Generic	\$40 Copay (Deductible Waived)	Paper Claim Submission Required	\$20 Copay (Deductible Waived)	Paper Claim Submission Required	\$20 Copay (Deductible Waived)	Paper Claim Submission Required	
Brand (Formulary/Preferred)	\$60 Copay (Deductible Waived)		\$40 Copay (Deductible Waived)		\$40 Copay (Deductible Waived)		
Brand (Non-Formulary/Non-Preferred)	\$60 Copay (Deductible Waived)		\$70 Copay (Deductible Waived)		\$70 Copay (Deductible Waived)		
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	\$100 Copay (Deductible Waived)		\$70 Copay (Deductible Waived)		20% up to \$150 max copay (Deductible Waived)		

²For 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), will prevail.

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

