CSEBO MEDICAL INSURANCE

TRADITIONAL PPO COMPARISON - OSSA

EFFECTIVE 1/1/2026 – 12/31/2026

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] Coinsruance (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] Coinsruance (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] Coinsruance (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)

[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.

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

[4]The 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).

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Anthem

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)		$10 Copay (Deductible Waived)		$10 Copay (Deductible Waived)	
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	Paper Claim Submission Required	$35 Copay (Deductible Waived)	Paper Claim Submission Required	$35 Copay (Deductible Waived)	Paper Claim Submission Required
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)		$20 Copay (Deductible Waived)		$20 Copay (Deductible Waived)	
Brand (Formulary/Preferred)	$60 Copay (Deductible Waived)		$40 Copay (Deductible Waived)		$40 Copay (Deductible Waived)	
Brand (Non-Formulary/Non-Preferred)	$60 Copay (Deductible Waived)	Paper Claim Submission Required	$70 Copay (Deductible Waived)	Paper Claim Submission Required	$70 Copay (Deductible Waived)	Paper Claim Submission Required
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	$100 Copay (Deductible Waived)		$70 Copay (Deductible Waived)		20% up to $150 max copay (Deductible Waived)	

[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.