CSEBO MEDICAL INSURANCE
HMO HEALTH PLAN COMPARISON – OSSA
EFFECTIVE 1/1/2026 – 12/31/2026

| PLAN NUMBER | ANTHEM BLUE CROSS | | KAISER PERMANENTE | KAISER PERMANENTE |
|---|---|---|---|---|
| GENERAL PLAN INFORMATION | HMO 30<br>IN-NETWORK ONLY | HMO 30 - SELECT NETWORK<br>IN-NETWORK ONLY | HMO 30<br>IN-NETWORK ONLY | DHMO 90<br>IN-NETWORK ONLY |
| **Annual Medical and Prescription Drug Combined Out-of-Pocket Limit[1]** | | | | |
| Individual/Individual in Family/Family | $5,000/$5,000/$10,000 | $5,000/$5,000/$10,000 | $1,500/$1,500/$3,000 | $3,000/$3,000/$6,000 |
| **Annual Medical Deductible** | | | | |
| Individual/Individual in Family/Family | $0 | $0 | $0 | $500/$500/$1,000 |
| **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 | Kaiser HMO |
| Referrals Required? | Yes | 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 (Deductible Waived) |
| Specialist Office Visit | $40 Copay | $40 Copay | $30 Copay | $40 Copay (Deductible Waived) |
| Diagnostic X-Ray and Lab Tests | No Charge | No Charge | No Charge | $10 copay per encounter (Deductible Waived) |
| Advanced Imaging | $100 Copay per Test | $100 Copay per Test | No Charge | 10% Coinsurance up to $150 Maximum (Deductible Waived) |
| **Inpatient Hospital Services** | | | | |
| Inpatient Hospitalization | 30% Coinsurance | 30% Coinsurance | No Charge | 10% Coinsurance (After Deductible) |
| **Outpatient Services** | | | | |
| Outpatient Surgery | 30% Coinsurance | 30% Coinsurance | $30 Copay per Procedure | 10% Coinsurance (After Deductible) |
| Outpatient Lab and Imaging | 30% Coinsurance | 30% Coinsurance | No Charge | $10 copay per encounter (Deductible Waived) |
| **Emergency Services** | | | | |
| Ambulance Services | $100 per Trip | $100 per Trip | $50 per Trip | $150 per Trip |
| Emergency Room | $200 Copay (Waived if Admitted) | $200 Copay (Waived if Admitted) | $50 Copay (Waived if Admitted) | 10% Coinsurance (After Deductible) |
| **Urgent Care** | | | | |
| Urgent Care Visits | $30 Copay | $30 Copay | $30 Copay | $30 Copay (Deductible Waived) |
| **Mental Health and Substance Abuse** | | | | |
| Inpatient Mental Health | 30% Coinsurance | 30% Coinsurance | No Charge | 10% Coinsurance (After Deductible) |
| Outpatient Mental Health Office Visit | $30 Copay | $30 Copay | $30 Copay | $30 Copay (Deductible Waived) |
| Other Outpatient Mental Health Services | 30% Coinsurance | 30% Coinsurance | No Charge | $15 Copay (Deductible Waived) |

[1]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.

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| PLAN NUMBER | ANTHEM BLUE CROSS HMO 30 | ANTHEM BLUE CROSS HMO 30 - SELECT NETWORK | KAISER PERMANENTE HMO 30 | KAISER PERMANENTE DHMO 90 |
|---|---|---|---|---|
| **GENERAL PLAN INFORMATION** | **IN-NETWORK ONLY** | **IN-NETWORK ONLY** | **IN-NETWORK ONLY** | **IN-NETWORK ONLY** |
| **Other Services** | | | | |
| Hearing Aids | Not Covered | Not Covered | Not Covered | Not Covered |
| Infertility Diagnosis & Treatment | 3-Cycle, Unlimited Rx | 3-Cycle, Unlimited Rx | 3-Cycle, Unlimited Rx | 3-Cycle, Unlimited Rx |
| **PRESCRIPTION DRUG BENEFITS** | **IN-NETWORK ONLY** | **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 | Combined with Medical |
| **Prescription Drug Deductible** | | | | |
| Per Individual | $0 | $0 | $0 | $0 |
| **Prescription Drug Formulary** | | | | |
| Formulary (Covered Drugs) | National 4-Tier | National 4-Tier | CA Commercial 3-Tier | CA Commercial 3-Tier |
| **Retail** | **30-Day Supply** | **30-Day Supply** | **30-Day Supply** | **30-Day Supply** |
| Generic | $15 Copay | $15 Copay | $15 Copay | $10 Copay (Deductible Waived) |
| Brand (Formulary/Preferred) | $30 Copay | $30 Copay | $30 Copay | $30 Day (Deductible Waived) |
| Brand (Non-Formulary/Non-Preferred) | $50 Copay | $50 Copay | $30 Copay | $30 Day (Deductible Waived) |
| 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) | 20% Coinsurance - Not to Exceed $250 (Deductible Waived) |
| **Mail Order** | **90-Day Supply** | **90-Day Supply** | **100-Day Supply** | **100-Day Supply** |
| Generic | $15 Copay | $15 Copay | $30 Copay | $20 Copay (Deductible Waived) |
| Brand (Formulary/Preferred) | $60 Copay | $60 Copay | $60 Copay | $60 Copay (Deductible Waived) |
| Brand (Non-Formulary/Non-Preferred) | $100 Copay | $100 Copay | $60 Copay | $60 Copay (Deductible Waived) |
| Specialty Rx (Specialty Pharmacy Only; 30-day supply) | 30% Coinsurance (Not to Exceed $300) | 30% Coinsurance (Not to Exceed $300) | Retail Only | 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.