

**CSEBO MEDICAL INSURANCE
HMO COMPARISON
EFFECTIVE 1/1/2026 - 12/31/2026**



PLAN NUMBER	KAISER PERMANENTE	
	HMO 10 IN-NETWORK ONLY	HMO 30 IN-NETWORK ONLY
GENERAL PLAN INFORMATION		
Annual Medical and Prescription Drug Combined Out-of-Pocket Limit¹		
Individual/Individual in Family/Family	\$1,500/\$1,500/\$3,000	\$1,500/\$1,500/\$3,000
Annual Medical Deductible		
Individual/Family	\$0	\$0
Physician/Diagnostic Services		
Preventive Care	\$0	\$0
TeleMedicine (Audio/Video Visits)	\$0	\$0
Primary Care Office Visit	\$10 Copay	\$30 Copay
Specialist Office Visit	\$10 Copay	\$30 Copay
Diagnostic X-Ray and Lab Tests	\$0	\$0
Advanced Imaging	\$0	\$0
Inpatient Hospital Services		
Inpatient Hospitalization	\$0	\$0
Outpatient Services		
Outpatient Surgery	\$10 Copay per Procedure	\$30 Copay per Procedure
Outpatient Lab and Imaging	\$0	\$0
Emergency Services		
Ambulance Services	\$50 per trip	\$50 per trip
Emergency Room	\$50 Copay (Waived if Admitted)	\$50 Copay (Waived if Admitted)
Urgent Care		
Urgent Care Visits	\$10 Copay	\$30 Copay

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.



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GENERAL PLAN INFORMATION		
Mental Health and Substance Abuse		
Inpatient Mental Health	\$0	\$0
Outpatient Mental Health Office Visit	\$10 Copay	\$30 Copay
Other Outpatient Mental Health Services	\$0	\$0
Other Services		
Hearing Aids	Not Covered	Not Covered
Infertility Diagnosis & Treatment	3-Cycle, Unlimited Rx	3-Cycle, Unlimited Rx
PRESCRIPTION DRUG BENEFITS		
Annual Prescription Drug Out-of-Pocket Limit		
Individual/Individual in Family/Family	Combined with Medical	Combined with Medical
Prescription Drug Deductible		
Per Individual	\$0	\$0
Prescription Drug Formulary		
Formulary (Covered Drugs)	CA Commercial 2-Tier	CA Commercial 3-Tier
Retail		
30-Day Supply		
Generic	\$10 Copay	\$15 Copay
Brand (Formulary/Preferred)	\$20 Copay	\$30 Copay
Brand (Non-Formulary/Non-Preferred)	\$20 Copay	\$30 Copay
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	\$20 Copay	50% Coinsurance (Not to Exceed \$200)
Mail Order		
100-Day Supply		
Generic	\$10 Copay	\$30 Copay
Brand (Formulary/Preferred)	\$20 Copay	\$60 Copay
Brand (Non-Formulary/Non-Preferred)	\$20 Copay	\$60 Copay
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	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.

