

PLAN NUMBER		PPO 90		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 Limit²							
Individual/Individual in Family/Family		\$2,000/\$2,000/\$6,000	Unlimited	\$3,000/\$3,000/\$9,000	Unlimited	\$5,000/\$5,000/\$12,700	Unlimited
Annual Medical Deductible² - Plan Deductible Applies Unless Otherwise Stated							
Individual/Individual in Family/Family		\$500/\$500/\$1,500	\$1,000/\$1,000/\$3,000	\$750/\$750/\$2,250	\$1,500/\$1,500/\$4,500	\$1,250/\$1,250/\$3,750 ³	\$2,500/\$2,500/\$7,500 ³
Coinsurance, After Deductible is Met							
Plan Pays:		90% (After Deductible)	50% Coinsurance (After Deductible)	80% (After Deductible)	50% Coinsurance (After Deductible)	70% (After Deductible)	50% Coinsurance (After Deductible)
Physician/Diagnostic Services							
Preventive Care		\$0 (Deductible Waived)	Not Covered	\$0 (Deductible Waived)	Not Covered	\$0 (Deductible Waived)	Not Covered
Primary Care Office Visit		\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)
Specialist Office Visit		\$10 Copay (Deductible Waived)	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		10% 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)		10% 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		10% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day	20% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day	30% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day
Outpatient Services							
Outpatient Surgery		10% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per day maximum	20% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per day maximum	30% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per day maximum
Outpatient Lab and Imaging		10% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per procedure maximum	20% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per procedure maximum	30% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per procedure maximum
Emergency Services							
Ambulance Services		10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		30% Coinsurance (After Deductible)	
Emergency Room		10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		30% Coinsurance (After Deductible)	
Urgent Care							
Urgent Care Visits		\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)
Mental Health and Substance Abuse							
Inpatient Mental Health		10% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day	20% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day	30% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day

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.

⁴\$250 deductible applies if utilization review is not obtained (waived for emergency admissions and outpatient freestanding surgery centers).



PLAN NUMBER		PPO 90		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
Mental Health and Substance Abuse (Continued)							
Outpatient Mental Health Office Visit	\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	
Other Outpatient Mental Health Services	10% 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	10% Coinsurance (After Deductible)	Not Covered	20% Coinsurance (After Deductible)	Not Covered	30% Coinsurance (After Deductible)	Not Covered	
Chiropractor Services	10% Coinsurance (After Deductible)	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	\$2,500 Maximum Benefit per Ear, Every 36 Months		\$2,500 Maximum Benefit per Ear, Every 36 Months		\$2,500 Maximum Benefit per Ear, Every 36 Months		
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	\$2,000/\$2,000/\$4,000 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							
Formulary (Covered Drugs)	National 3-Tier		National 3-Tier		Essential 4-Tier		
Retail		30-Day Supply		30-Day Supply		30-Day Supply	
Generic	\$5 min Copay/ or 20% up to a	Paper claim submission required	\$10 Copay (Deductible Waived)	Paper claim submission required	\$10 Copay (Deductible Waived)	Paper claim submission required	
Brand (Formulary/Preferred)	\$25 Max Copay (Deductible Waived)		\$20 Copay (Deductible Waived)		\$20 Copay (Deductible Waived)		
Brand (Non-Formulary/Non-Preferred)			\$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	\$5 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)			\$40 Copay (Deductible Waived)		\$40 Copay (Deductible Waived)		
Brand (Non-Formulary/Non-Preferred)			\$70 Copay (Deductible Waived)		\$70 Copay (Deductible Waived)		
Specialty Rx (Specialty Pharmacy Only; 30-day supply)			\$70 Copay (Deductible Waived)		20% up to \$150 max copay (Deductible Waived)		

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.

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.



PLAN NUMBER	ANTHEM BLUE CROSS					
GENERAL PLAN INFORMATION	CDHP PPO 90		CDHP PPO 80		CDHP PPO 60	
	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹
Annual Medical and Prescription Drug Combined Out-of-Pocket Limit						
Individual/Individual in Family/Family	\$3,000/\$6,000/\$6,000 (Combined Medical & Rx Out-of-Pocket Max)	Unlimited	\$5,000/\$5,000/\$10,000 (Combined Medical & Rx Out-of-Pocket Max) ²	Unlimited	\$8,700/\$8,700/\$17,400 (Combined Medical & Rx Out-of-Pocket Max) ²	Unlimited
Annual Combined Medical Deductible and Prescription Drug Deductible - Plan deductible applies unless otherwise stated						
Individual/Individual in Family/Family	\$1,750/\$3,500/\$3,500	\$4,000/\$8,000/\$8,000	\$1,850/\$3,500/\$3,700 ²	\$4,500/\$4,500/\$9,000 ²	\$3,500/\$3,500/\$7,000 ²	\$5,000/\$5,000/\$10,000 ²
Plan Information						
Type of Plan	Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)	
Referrals Required?	No		No		No	
Plan Coinsurance	Plan Pays 90% (After Deductible)	Plan Pays 50% (After Deductible)	Plan Pays 80% (After Deductible)	Plan Pays 50% (After Deductible)	Plan Pays 60% (After Deductible)	Plan Pays 50% (After Deductible)
Health Savings Account (HSA) Compatibility						
HSA-Compatible Plan:	Yes		Yes		Yes	
2027 Individual Maximum Contribution:	\$4,500		\$4,500		\$4,500	
227 Family Maximum Contribution:	\$9,000		\$9,000		\$9,000	
Over 55 HSA Contribution Catch-Up:	\$1,000		\$1,000		\$1,000	
Physician/Diagnostic Services						
Preventive Care	\$0 (Deductible Waived)	50% Coinsurance (After Deductible)	\$0 (Deductible Waived)	50% Coinsurance (After Deductible)	\$0 (Deductible Waived)	50% Coinsurance (After Deductible)
Primary Care Office Visit	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	\$45 Copay (After Deductible)	50% Coinsurance (After Deductible)
Specialist Office Visit	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	\$45 Copay (After Deductible)	50% Coinsurance (After Deductible)
Diagnostic X-Ray and Lab Tests	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)
Advanced Imaging (MRI/PET/CAT Scans)	10% 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	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$800 per procedure maximum
Inpatient Hospital Services						
Inpatient Hospitalization	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 maximum per day	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 maximum per day	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 maximum per day
Outpatient Services						
Outpatient Surgery	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$350 maximum	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$350 maximum	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$350 maximum
Outpatient Lab and Imaging	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$350 maximum	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$350 maximum	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$350 maximum
Emergency Services						
Ambulance Services	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		40% Coinsurance (After Deductible)	
Emergency Room	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		40% Coinsurance (After Deductible; \$250 Copay, Waived if Admitted)	

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 both per person deductible and per person out-of-pocket maximum. In addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.

³The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum. In addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum.

PLAN NUMBER	ANTHEM BLUE CROSS					
	CDHP PPO 90		CDHP PPO 80		CDHP PPO 60	
GENERAL PLAN INFORMATION	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹
Urgent Care						
Urgent Care Visits	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	\$45 Copay (After Deductible)	50% Coinsurance (After Deductible)
Mental Health and Substance Abuse						
Inpatient Mental Health	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 maximum	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 maximum	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 maximum
Outpatient Mental Health Office Visit	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	\$45 Copay (After Deductible)	50% Coinsurance (After Deductible)
Other Outpatient Mental Health Services	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)
Other Services						
Acupuncture	10% Coinsurance (After Deductible), maximum of 20 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), maximum of 20 visits per calendar year, then plan pays 0%	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	40% Coinsurance (After Deductible), maximum of 20 visits per calendar year, then plan pays 0%	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%
Chiropractor Services	10% Coinsurance (After Deductible), 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), 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%	40% Coinsurance (After Deductible), 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%
Hearing Aids	\$2,500 Maximum Benefit per Ear, Every 36 Months		\$2,500 Maximum Benefit per Ear, Every 36 Months		\$2,500 Maximum Benefit per Ear, Every 36 Months	
Infertility Diagnosis & Treatment	Not Covered		Not Covered		Not Covered	
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	Combined with Medical		Combined with Medical		Combined with Medical	
Prescription Drug Deductible						
Individual/Individual in Family/Family	Combined with Medical		Combined with Medical		Combined with Medical	
Prescription Drug Formulary						
Formulary (Covered Drugs)	National 4-Tier		National 4-Tier		National 4-Tier	
Retail	30-Day Supply		30-Day Supply		30-Day Supply	
Generic	\$10 Copay (After Deductible)				\$20 Copay (After Deductible)	
Brand (Formulary/Preferred)	\$30 Copay (After Deductible)				\$45 Copay (After Deductible)	
Brand (Non-Formulary/Non-Preferred)	\$30 Copay (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible; Not to Exceed \$250)	50% Coinsurance (After Deductible)	\$60 Copay (After Deductible)	50% Coinsurance (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	20% Coinsurance (After Deductible; Not to Exceed \$150)				20% Coinsurance (After Deductible; Not to Exceed \$150)	
Mail Order	90-Day Supply		90-Day Supply		90-Day Supply	
Generic	\$20 Copay (After Deductible)				\$40 Copay (After Deductible)	
Brand (Formulary/Preferred)	\$60 Copay (After Deductible)				\$90 Copay (After Deductible)	
Brand (Non-Formulary/Preferred)	\$60 Copay (After Deductible)	Paper claim submission required	20% Coinsurance (After Deductible; Not to Exceed \$250)	Paper claim submission required	\$120 Copay (After Deductible)	Paper claim submission required
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	20% (After Deductible; Not to Exceed \$150)				20% (After Deductible; Not to Exceed \$150)	

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.

**CSEBO MEDICAL INSURANCE
CONSUMER-DIRECTED HEALTH PLANS (CDHP) COMPARISON
EFFECTIVE 1/1/2027 - 12/31/2027**



PLAN NUMBER			
GENERAL PLAN INFORMATION		<u>CDHP DHMO 90 IN-NETWORK ONLY</u>	<u>CDHP DHMO 80 IN-NETWORK ONLY</u>
Annual Medical and Prescription Drug Combined Out-of-Pocket Limit			
Individual/Individual in Family/Family		\$3,500/\$3500/\$7,000 Combined Medical & Rx Out-of-Pocket Max) ³	\$4,500/\$4,500/\$9,000 Combined Medical & Rx Out-of-Pocket Max) ³
Annual Combined Medical Deductible and Prescription Drug Deductible - Plan deductible applies unless otherwise stated			
Individual/Individual in Family/Family		\$1,750/\$3,500/\$3,500 ²	\$2,000/\$3,500/\$4,000 ²
Plan Information			
Type of Plan	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Referrals Required?	Yes	Yes	Yes
Plan Coinsurance	Plan Pays 90% (After Deductible)	Plan Pays 80% (After Deductible)	Plan Pays 60% (After Deductible)
Health Savings Account (HSA) Compatibility			
HSA-Compatible Plan:	Yes	Yes	Yes
2027 Individual Maximum Contribution:	\$4,500	\$4,500	\$4,500
2027 Family Maximum Contribution:	\$9,000	\$9,000	\$9,000
Over 55 HSA Contribution Catch-Up:	\$1,000	\$1,000	\$1,000
Physician/Diagnostic Services			
Preventive Care	\$0 (Deductible Waived)	\$0 (Deductible Waived)	\$0 (Deductible Waived)
Primary Care Office Visit	10% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	\$40 Copay (After Deductible)
Specialist Office Visit	10% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	\$40 Copay (After Deductible)
Diagnostic X-Ray and Lab Tests	10% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Advanced Imaging (MRI/PET/CAT Scans)	10% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	40% Coinsurance (After Deductible; Not to Exceed \$150 per Procedure)
Inpatient Hospital Services			
Inpatient Hospitalization	10% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Outpatient Services			
Outpatient Surgery	10% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Outpatient Lab and Imaging	10% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Emergency Services			
Ambulance Services	10% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Emergency Room	10% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	\$250 Copay (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 both per person deductible and per person out-of-pocket maximum. In addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.

³The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum. In addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum.



**CSEBO MEDICAL INSURANCE
CONSUMER-DIRECTED HEALTH PLANS (CDHP) COMPARISON
EFFECTIVE 1/1/2027 - 12/31/2027**



PLAN NUMBER			
GENERAL PLAN INFORMATION		<u>CDHP DHMO 90 IN-NETWORK ONLY</u>	<u>CDHP DHMO 80 IN-NETWORK ONLY</u>
Urgent Care			
Urgent Care Visits		10% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)
Mental Health and Substance Abuse			
Inpatient Mental Health		10% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)
Outpatient Mental Health Office Visit		10% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)
Other Outpatient Mental Health Services		10% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Other Services			
Acupuncture		N/A	N/A
Chiropractor Services		N/A	N/A
Hearing Aids		N/A	N/A
Infertility Diagnosis & Treatment		3-Cycle, Unlimited Rx (After Deductible)	3-Cycle, Unlimited Rx (After Deductible)
PRESCRIPTION DRUG BENEFITS		IN-NETWORK ONLY	IN-NETWORK ONLY
Annual Prescription Drug Out-of-Pocket Limit			
Individual/Individual in Family/Family		Combined with Medical	Combined with Medical
Prescription Drug Deductible			
Individual/Individual in Family/Family		Combined with Medical	Combined with Medical
Prescription Drug Formulary			
Formulary (Covered Drugs)		CA Commercial 3-Tier	CA Commercial 3-Tier
Retail		30-Day Supply	30-Day Supply
Generic		\$10 Copay (After Deductible)	20% Coinsurance (After Deductible)
Brand (Formulary/Preferred)		\$30 Copay (After Deductible)	20% Coinsurance (After Deductible)
Brand (Non-Formulary/Non-Preferred)		\$30 Copay (After Deductible)	20% Coinsurance (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)		20% Coinsurance (After Deductible; Not to Exceed \$150)	20% Coinsurance (After Deductible; Not to Exceed \$150)
Mail Order		100-Day Supply	100-Day Supply
Generic		\$20 Copay (After Deductible)	20% Coinsurance (After Deductible)
Brand (Formulary/Preferred)		\$60 Copay (After Deductible)	20% Coinsurance (After Deductible)
Brand (Non-Formulary/Preferred)		\$60 Copay (After Deductible)	20% Coinsurance (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)		20% Coinsurance (After Deductible; Not to Exceed \$150)	20% Coinsurance (After Deductible; Not to Exceed \$150)

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PLAN NUMBER	ANTHEM BLUE CROSS		KAISER PERMANENTE	
	SELECT HMO 10 IN-NETWORK ONLY	SELECT HMO 30 IN-NETWORK ONLY	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/\$4,500	\$5,000/\$5,000/\$10,000	\$1,500/\$1,500/\$3,000	\$1,500/\$1,500/\$3,000
Annual Medical Deductible				
Individual/Family	\$0	\$0	\$0	\$0
Physician/Diagnostic Services				
Preventive Care	\$0	\$0	\$0	\$0
TeleMedicine (Audio/Video Visits)	\$0	\$0	\$0	\$0
Primary Care Office Visit	\$10 Copay	\$30 Copay	\$10 Copay	\$30 Copay
Specialist Office Visit	\$10 Copay	\$40 Copay	\$10 Copay	\$30 Copay
Diagnostic X-Ray and Lab Tests	\$0	\$0	\$0	\$0
Advanced Imaging	\$0	\$100 Copay per Test	\$0	\$0
Inpatient Hospital Services				
Inpatient Hospitalization	\$0	30% Coinsurance	\$0	\$0
Outpatient Services				
Outpatient Surgery	\$0	30% Coinsurance	\$10 Copay per Procedure	\$30 Copay per Procedure
Outpatient Lab and Imaging	\$0	30% Coinsurance	\$0	\$0
Emergency Services				
Ambulance Services	\$0	\$100 per trip	\$50 per trip	\$50 per trip
Emergency Room	\$50 Copay (Waived if Admitted)	\$200 Copay (Waived if Admitted)	\$50 Copay (Waived if Admitted)	\$50 Copay (Waived if Admitted)
Urgent Care				
Urgent Care Visits	\$10 Copay	\$30 Copay	\$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.





PLAN NUMBER	ANTHEM BLUE CROSS		KAISER PERMANENTE	
	SELECT HMO 10	SELECT HMO 30	HMO 10	HMO 30
GENERAL PLAN INFORMATION	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK ONLY
Mental Health and Substance Abuse				
Inpatient Mental Health	\$0	30% Coinsurance	\$0	\$0
Outpatient Mental Health Office Visit	\$10 Copay	\$30 Copay	\$10 Copay	\$30 Copay
Other Outpatient Mental Health Services	\$0	30% Coinsurance	\$0	\$0
Other Services				
Hearing Aids	1 per Ear, Every 36 Months	\$2,500 Maximum Benefit per Ear, Every 36 Months	\$2,500 Maximum Benefit per Ear, Every 36 Months	\$2,500 Maximum Benefit per Ear, Every 36 Months
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 3-Tier	National 4-Tier	CA Commercial 2-Tier	CA Commercial 3-Tier
Retail				
	30-Day Supply	30-Day Supply	30-Day Supply	30-Day Supply
Generic	\$10 Copay	\$15 Copay	\$10 Copay	\$15 Copay
Brand (Formulary/Preferred)	\$20 Copay	\$30 Copay	\$20 Copay	\$30 Copay
Brand (Non-Formulary/Non-Preferred)	\$20 Copay	\$50 Copay	\$20 Copay	\$30 Copay
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	\$20 Copay	30% Coinsurance (Not to Exceed \$150)	\$20 Copay	50% Coinsurance (Not to Exceed \$200)
Mail Order				
	90-Day Supply	90-Day Supply	100-Day Supply	100-Day Supply
Generic	\$20 Copay	\$15 Copay	\$10 Copay	\$30 Copay
Brand (Formulary/Preferred)	\$40 Copay	\$60 Copay	\$20 Copay	\$60 Copay
Brand (Non-Formulary/Non-Preferred)	\$40 Copay	\$100 Copay	\$20 Copay	\$60 Copay
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	\$40 Copay	30% Coinsurance (Not to Exceed \$300)	Retail Only	Retail Only

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CSEBO DENTAL INSURANCE
DELTA DENTAL PPO
ANTHEM BLUE CROSS CUSTOM NETWORK PPO
EFFECTIVE 1/1/2027 - 12/31/2027



PLAN NAME		DELTA DENTAL PPO ¹		ANTHEM BLUE CROSS CUSTOM NETWORK PPO	
GENERAL PLAN INFORMATION		PREMIER & NON-DELTA DENTAL PPO PROVIDERS		ANTHEM DENTAL PPO PROVIDERS	OUT-OF-NETWORK PROVIDERS
Calendar Year Annual Maximum		\$2,500	\$2,500	\$4,000	\$250
Incentive Levels					
Percentage level increases 10% for each consecutive year the dentist is visited, to a maximum of 100%.		70/80/90/100%	70/80/90/100%	N/A	N/A
Diagnostic and Preventive Benefits					
Prophylaxis (Cleaning) Treatments	Plan Pays 100%; limited to 2 per calendar year ²	Plan Pays 100%; limited to 2 per calendar year ²	Plan Pays 100%; limited to 2 per calendar year ²	Plan Pays 100%; limited to 2 per calendar year ³	Not Covered
Oral Examinations	Plan Pays 100%; limited to 2 per calendar year ²	Plan Pays 100%; limited to 2 per calendar year ²	Plan Pays 100%; limited to 2 per calendar year ²	Plan Pays 100% ³	Not Covered
Full-Mouth X-Rays	Plan Pays 100%; limited to 1 per 36 months ²	Plan Pays 100%; limited to 1 per 36 months ²	Plan Pays 100%; limited to 1 per 36 months ²	Plan Pays 100% ³	Not Covered
Bitewing X-Rays	Plan Pays 100%; upon provider request, maximum of 2 per calendar year ²	Plan Pays 100%; upon provider request, maximum of 2 per calendar year ²	Plan Pays 100%; upon provider request, maximum of 2 per calendar year ²	Plan Pays 100% ³	Not Covered
Periodontal Scaling and Root Planing	Plan Pays 100%; limited to 1 each quadrant every 24 months	Plan Pays 100%; limited to 1 each quadrant every 24 months	Plan Pays 100%; limited to 1 each quadrant every 24 months	Plan Pays 100% ³	Not Covered
Basic Benefits					
Oral Surgery - Extractions	Plan Pays 70/80/90/100%; limited to once per tooth per lifetime	Plan Pays 70/80/90/100%; limited to once per tooth per lifetime	Plan Pays 70/80/90/100%; limited to once per tooth per lifetime	Plan Pays 100%	Not Covered
Oral Surgery - Other Surgical Procedures	Plan Pays 50-100% depending on procedure	Plan Pays 50-100% depending on procedure	Plan Pays 50-100% depending on procedure	Plan Pays 100%	Not Covered
Restorative Procedures - Amalgam, Silicate or Composite (Resin) Restorations (Fillings)	Plan Pays 70/80/90/100%; limited to once per surface, per tooth within a 2 year period	Plan Pays 70/80/90/100%; limited to once per surface, per tooth within a 2 year period	Plan Pays 70/80/90/100%; limited to once per surface, per tooth within a 2 year period	Plan Pays 100%	Not Covered
Endodontic Treatments	Plan Pays 70/80/90/100%; limitations apply	Plan Pays 70/80/90/100%; limitations apply	Plan Pays 70/80/90/100%; limitations apply	Plan Pays 100%	Not Covered
Basic Benefits (continued)					
Periodontic Treatment	Plan Pays 70/80/90/100%; limitations apply	Plan Pays 70/80/90/100%; limitations apply	Plan Pays 70/80/90/100%; limitations apply	Plan Pays 100%	Not Covered
Sealants	Plan Pays 70/80/90/100%; limited to once per tooth within 3 year period, up to age 14.	Plan Pays 70/80/90/100%; limited to once per tooth within 3 year period, up to age 14.	Plan Pays 70/80/90/100%; limited to once per tooth within 3 year period, up to age 14.	Plan Pays 100%	Not Covered
Crowns, Inlays, Onlays and Cast Restoration Benefits					
Crowns, Inlays, Onlays and Cast Restoration	Plan Pays 70/80/90/100%; service on the same tooth only once every 5 years	Plan Pays 70/80/90/100%; service on the same tooth only once every 5 years	Plan Pays 70/80/90/100%; service on the same tooth only once every 5 years	Plan Pays 100%	Not Covered



CSEBO DENTAL INSURANCE
DELTA DENTAL PPO
ANTHEM BLUE CROSS CUSTOM NETWORK PPO
EFFECTIVE 1/1/2027 - 12/31/2027



PLAN NAME		DELTA DENTAL PPO ¹		ANTHEM BLUE CROSS CUSTOM NETWORK PPO	
GENERAL PLAN INFORMATION		DELTA DENTAL PPO PROVIDERS	PREMIER & NON-DELTA DENTAL PPO PROVIDERS	ANTHEM DENTAL PPO PROVIDERS	OUT-OF-NETWORK PROVIDERS
Prosthodontic Benefits					
Implants		Plan Pays 50%; limited to once every 5 years	Plan Pays 50%; limited to once every 5 years	Plan pays 50%; up to \$2,000 Annually	Not Covered
Removable - Partial Dentures, Full Dentures		Plan Pays 50%; limited to once every 5 years	Plan Pays 50%; limited to once every 5 years	Plan Pays 50%	Not Covered
Fixed - Inlays, Onlays, Bridges		Plan Pays 50%; limited to once every 5 years	Plan Pays 50%; limited to once every 5 years	Plan Pays 50%	Not Covered
Orthodontia Benefits					
Coverage Eligibility		Adults and Children	Adults and Children	Adults and Children	Adults and Children
Coverage Percentage		100%	100%	100%	100%
Lifetime Individual Maximum		\$3,000	\$3,000	\$2,000	\$2,000

¹Reimbursement to providers is based on the PPO contracted fee for PPO dentists. Premier contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

²2 cleanings, Exams and X-ray costs do not count towards the calendar year annual maximum.

³2 cleanings, Exams and X-ray costs count towards the calendar year annual maximum.

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CSEBO VISION INSURANCE
VSP PPO COMPARISON
EFFECTIVE 1/1/2027 - 12/31/2027



GENERAL PLAN INFORMATION		BASE		BUY-UP	
Service Frequencies		In-Network	Out-of-Network	In-Network	Out-of-Network
Exam Every		12 Months	12 Months	12 Months	12 Months
Lenses Every		12 Months	12 Months	12 Months	12 Months
Frame Every		24 Months	24 Months	12 Months	12 Months
Benefits					
Copays		\$10	\$10	\$10	\$10
Examination		Covered After Copay	Up To \$45	Covered After Copay	Up To \$45
Contact Lens Fitting		Covered After Copay	Up To \$45	Covered After Copay	Up To \$45
Retinal Imaging		Up to \$39, After \$10 Copay	Up To \$45	Covered After Copay	Up To \$45
Prescription Glasses					
Coverage		Contacts OR Glasses		Contacts AND Glasses	
Frame Allowance		\$200	Up To \$70	\$300	Up To \$70
Elective Contact Allowance		\$200	Up To \$90	\$300	Up To \$105
Lenses					
Single Vision		Covered After Copay	Up To \$30	Covered After Copay	Up To \$30
Lined Bifocal		Covered After Copay	Up To \$50	Covered After Copay	Up To \$50
Lined Trifocal		Covered After Copay	Up To \$65	Covered After Copay	Up To \$65
Lense Enhancements (Negotiated Member Share Savings of 20-25%) ¹					
Anti-Reflective Coatings		\$41 - \$85	Provider Rate	\$40 copay ²	Provider Rate
Custom Progressive Lenses		\$150 - \$175	Provider Rate	\$150 - \$175	Provider Rate
Edge Polish		\$36	Provider Rate	\$36	Provider Rate
Light Filter		\$15	Provider Rate	\$15	Provider Rate
High Index Lenses		\$50 - \$125	Provider Rate	\$50 - \$125	Provider Rate
Light-Reactive Lenses		\$75	Provider Rate	\$75	Provider Rate
Polarized Lenses		\$57 - \$101	Provider Rate	\$57 - \$101	Provider Rate
Impact-Resistant Lenses		\$35	Provider Rate	\$35	Provider Rate
Premium Progressive Lenses		\$95 - \$105	Provider Rate	\$95 - \$105	Provider Rate
Scratch-Resistant Coating		\$17 - \$33	Provider Rate	\$17 - \$33	Provider Rate
Standard Progressive Lenses		No Charge	Provider Rate	No Charge	Provider Rate
Tinted (Colored) Lenses		\$15 - \$17	Provider Rate	\$15 - \$17	Provider Rate
UV Protection		\$16	Provider Rate	\$16	Provider Rate

¹Costco Optical pricing already includes member savings.

²Costco Optical pricing may vary.

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**EMPLOYEE ASSISTANCE PROGRAM
OPTUM
EFFECTIVE 1/1/2027 - 12/31/2027**



TYPE OF PLAN		EMPLOYEE ASSISTANCE PROGRAM ¹
GENERAL PLAN INFORMATION		IN-NETWORK BENEFITS
Contact Information - 24-Hours per Day/7-Days per Week		
	Phone	(888) 444-8624
	Web	www.liveandworkwell.com
	Access Code	CSEBO
EAP Benefits		Copays/Coinsurance
	5 Face-To-Face Visits per Problem per Year	\$0
Covered Visits²		Copays/Coinsurance
	Child/Parenting Services	\$0
	Adult/Elder Support	\$0
	Financial Resources	\$0
	Legal/Mediation Resources	\$0
	Chronic Condition Support	\$0
	Life Learning/Educational Support Services	\$0
	Convenience Services	\$0

¹The Employee Assistance Program is a benefit that is provided to each benefit-eligible employee of the SPUSD at no charge. You do not need to "select" this plan, eligible employees will automatically have access to these benefits.

² You must obtain prior-authorization through Optum prior to face-to-face consulting services. Please contact (888) 444-8624 to obtain authorization for face-to-face visits and for access to the full WorkLife program.

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