CSEBO MEDICAL INSURANCE
HMO COMPARISON
EFFECTIVE 1/1/2022 – 12/31/2022

Anthem Blue Cross

KAISER PERMANENTE®

PLAN NUMBER GENERAL PLAN INFORMATION	HMO IN-NETWORK ONLY	HMO IN-NETWORK ONLY
Annual Medical and Prescription Drug Combined Out-of-Pocket Limit		
Individual/Family	$1,500/$4,500	$1,500/$3,000
Annual Medical Deductible		
Individual/Family	$0	$0
Plan Information		
Type of Plan	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Referrals Required?	Yes	Yes
Physician/Diagnostic Services		
Preventive Care	$0	$0
TeleMedicine (Audio/Video Visits)	$0	$0
Primary Care Office Visit	$10 copay	$10 copay
Specialist Office Visit	$10 copay	$10 copay
Diagnostic X-Ray and Lab Tests	$0	$0
Advanced Imaging	$0	$0
Inpatient Hospital Services		
Inpatient Hospitalization	$0	$0
Outpatient Services		
Outpatient Surgery	$0	$10 copay per procedure
Outpatient Lab and Imaging	$0	$0
Emergency Services		
Ambulance Services	$0	$50 per trip
Emergency Room	$50 copay, waived if admitted	$50 copay, waived if admitted
Urgent Care	**In-Network**	**In-Network**
Urgent Care Visits	$10	$10
Mental Health and Substance Abuse		
Inpatient Mental Health	$0	$0
Outpatient Mental Health Office Visit	$10 copay	$10 copay

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Mental Health and Substance Abuse (Continued)		
Other Outpatient Mental Health Services	$0	$0
Other Practitioner Visits		
Acupuncture	$10 copay for medically necessary acupuncture, referral required	$10 copay, combined 30 visits per 12-month period for acupuncure and chiropractic services, referral not required
Chiropractic Services	$10 copay, rehabilitative care only, referral required, per 60-day period	$10 copay, combined 30 visits per 12-month period for acupuncure and chiropractic services, referral not required
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**
Annual Prescription Drug Out-of-Pocket Limit		
Individual/Family	Combined with Medical	Combined with Medical
Prescription Drug Deductible		
Per Individual	$0	$0
Prescription Drug Formulary		
Formulary (Covered Drugs)	National 3-Tier	CA Commercial 2-Tier
Retail	**30-Day Supply**	**30-Day Supply**
Generic	$10 copay	$10 copay
Brand (Formulary/Preferred)	$20 copay	$20 copay
Brand (Non-Formulary/Non-Preferred)	$20 copay	$20 copay
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	$20 copay	$20 copay
Mail Order	**90-Day Supply**	**100-Day Supply**
Generic	$20 copay	$10 copay
Brand (Formulary/Preferred)	$40 copay	$20 copay
Brand (Non-Formulary/Non-Preferred)	$40 copay	$20 copay

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.

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