CSEBO MEDICAL INSURANCE
HEALTH PLAN COMPARISON
EFFECTIVE 1/1/2023 – 12/31/2023

CARRIER	ANTHEM BLUE CROSS				KAISER PERMANENTE	
PLAN NAME	PPO 80		CDHP PPO 90		HMO 10	CDHP HMO $1,500
GENERAL PLAN INFORMATION	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK ONLY	IN-NETWORK ONLY
Annual Medical Out-of-Pocket Limit						
Individual/Individual in Family/Family	$3,000/$3,000/$9,000[2]	Unlimited	$3,000/$6,000/$6,000 (Combined Medical & Rx Out-of-Pocket Max)	Unlimited	$1,500/$1,500/$3,000[3]	$3,000/$3,000/$6,000 (Combined Medical & Rx Out-of-Pocket Max)[3]
Annual Medical Deductible - Plan Deductible Applies Unless Otherwise Stated						
Individual/Individual in Family/Family	$750/$750/$2,250[2]	$1,500/$1,500/$4,500[2]	$1,500/$3,000/$3,000 (Combined Medical & Rx Deductible)	$4,000/$8,000/$8,000 (Combined Medical & Rx Deductible)	$0	$1,500/$3,000/$3,000 (Combined Medical & Rx Deductible)
Plan Information						
Type of Plan	Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Health Maintenace Organization (HMO)	Health Maintenace Organization (HMO)
Referrals Required?	No		No		Yes	Yes
Plan Coinsurance	Plan Pays 80% (After Deductible)	Plan Pays 50% Coinsurance (After Deductible)	Plan Pays 90% (After Deductible)	Plan Pays 50% Coinsurance (After Deductible)	N/A	Plan Pays 90% (After Deductible)
Health Savings Account (HSA) Compatibility:						
HSA-Compatible Plan?	No		Yes		No	Yes
2023 Individual Maximum Contribution	N/A		$3,850		N/A	$3,850
2023 Family Maximum Contribution	N/A		$7,750		N/A	$7,750
Over 55 HSA Contribution Catch-Up	N/A		$1,000		N/A	$1,000
Physician/Diagnostic Services						
Preventive Care	$0	Not Covered	$0	Not Covered	$0	$0
Primary Care Office Visit	$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$10 Copay	10% Coinsurance (After Deductible)
Specialist Office Visit	$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$10 Copay	10% Coinsurance (After Deductible)
Diagnostic X-Ray and Lab Tests	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$0	10% Coinsurance (After Deductible)
Advanced Imaging (MRI/PET/CAT Scans)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $800 per Procedure Maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $800 per Procedure Maximum	$0	10% Coinsurance (After Deductible)
Inpatient Hospital Services						
Inpatient Hospitalization	20%[4] Coinsruance (After Deductible)	50% Coinsurance (After Deductible)[4] up to $1,000 Maximum per Day	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $1,000 Maximum per Day	$0	10% Coinsurance (After Deductible)
Outpatient Services						
Outpatient Surgery	20%[4] Coinsurance (After Deductible)	50% Coinsurance (After Deductible)[4] up to $350 per Day Maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $350 per Day Maximum	$10 Copay (Per Procedure)	10% Coinsurance (After Deductible)
Outpatient Lab and Imaging	20%[4] Coinsurance (After Deductible)	50% Coinsurance (After Deductible)[4] up to $350 per Procedure Maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $350 per Procedure Maximum	$0	10% Coinsurance (After Deductible)
Emergency Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
Ambulance Services	20% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		$50 Copay (Per Trip)	10% Coinsurance (After Deductible)
Emergency Room	20% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		$50 Copay (Waived if Admitted)	10% Coinsurance (After Deductible)
Urgent Care						
Urgent Care Visits	$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$10 Copay	10% 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]For Anthem PPO 80: 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]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.
[4]$250 deductible applies if utilization review is not obtained (waived for emergency admissions and outpatient freestanding surgery centers).

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PLAN NAME	**PPO 80**		**CDHP PPO 90**		**HMO 10**	**CDHP HMO $1,500**
Mental Health and Substance Abuse						
Inpatient Mental Health	20%[4] Coinsurance (After Deductible)	50%[4] Coinsurance (After Deductible) up to $1,000 per Day Maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to $1,000 per Day Maximum	$0	10% Coinsurance (After Deductible)
Outpatient Mental Health Office Visit	$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$10 Copay	10% Coinsurance (After Deductible)
Other Outpatient Health Services	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$0	10% Coinsurance (After Deductible)
Other Services						
Acupuncture	20% Coinsurance (After Deductible)	Not Covered	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%	N/A	N/A
Chiropractor Services	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	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%	N/A	N/A
Hearing Aids	$500 Maximum Benefit per Ear, Every 12 Months		$500 Maximum Benefit per Ear, Every 12 Months		No Coverage	No Coverage
Infertility Diagnosis & Treatment	$20K Lifetime Maximum, 50% Coinsurance		$20K Lifetime Maximum, 50% Coinsurance		$10 Office Copay, $0 Inpatient, $0 Lab, Imaging, & Special Encounter	No Coverage
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**
Annual Prescription Drug Out-of-Pocket Limit						
Individual/Individual in Family/Family	$2,000/$2,000/$4,000[2]	Unlimited	Combined with Medical		Combined with Medical	Combined with Medical
Prescription Drug Deductible						
Per Individual	$0		Combined with Medical		$0	Combined with Medical
Prescription Drug Formulary						
Fomulary (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 (Deductible Waived)	Paper Claim Submission Required	$10 Copay (After Deductible)	Paper Claim Submission Required	$10 Copay	$10 Copay (After Deductible)
Brand (Formulary/Preferred)	$20 Copay (Deductible Waived)		$30 Copay (After Deductible)		$20 Copay	$20 Copay (After Deductible)
Brand (Non-Formulary/Non-Preferred)	$35 Copay (Deductible Waived)		$30 Copay (After Deductible)		$20 Copay	$35 Copay (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	Same as Retail Brand		20% (After Deductible; Not to Exceed $150)		$20 Copay	20% (After Deductible; Not to Exceed $150)
Mail Order	**90-Day Supply**		**90-Day Supply**		**100-Day Supply**	**100-Day Supply**
Generic	$20 Copay (Deductible Waived)	Paper Claim Submission Required	$20 Copay (After Deductible)	Paper Claim Submission Required	$10 Copay	$20 Copay (After Deductible)
Brand (Formulary/Preferred)	$40 Copay (Deductible Waived)		$60 Copay (After Deductible)		$20 Copay	$60 Copay (After Deductible)
Brand (Non-Formulary/Non-Preferred)	$70 Copay (Deductible Waived)		$60 Copay (After Deductible)		$20 Copay	$60 Copay (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	$70 Copay (Deductible Waived)		20% (After Deductible; Not to Exceed $150)		$20 Copay	20% (After Deductible; Not to Exceed $150)

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[4]$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.