CSEBO MEDICAL INSURANCE
HEALTH PLAN COMPARISON
EFFECTIVE 1/1/2024 – 12/31/2024

CARRIER	ANTHEM BLUE CROSS				KAISER PERMANENTE	
PLAN NAME	INDEMNITY IV PPO		CDHP PPO 90		HMO 30	CDHP HMO $1,600
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	$2,000/$2,000/$4,000[2]	Unlimited	$3,000/$6,000/$6,000 (Combined Medical & Rx Out-of-Pocket Max)	Unlimited	$1,500/$1,500/$3,000[3]	$3,200/$3,200/$6,400 (Combined Medical & Rx Out-of-Pocket Max)[3]
Annual Medical Deductible - Plan Deductible Applies Unless Otherwise Stated						
Individual/Individual in Family/Family	$800/$800/$2,400[2]	$800/$800/$2,400[2]	$1,600/$3,200/$3,200 (Combined Medical & Rx Deductible)	$4,000/$8,000/$8,000 (Combined Medical & Rx Deductible)	$0	$1,600/$3,200/$3,200 (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 85% (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
2024 Individual Maximum Contribution	N/A		$4,150		N/A	$4,150
2024 Family Maximum Contribution	N/A		$8,300		N/A	$8,300
Over 55 HSA Contribution Catch-Up	N/A		$1,000		N/A	$1,000
Physician/Diagnostic Services						
Preventive Care	No Charge	Not Covered	No Charge	Not Covered	No Charge	No Charge
Primary Care Office Visit	15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$30 Copay	10% Coinsurance (After Deductible)
Specialist Office Visit	15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$30 Copay	10% Coinsurance (After Deductible)
Diagnostic X-Ray and Lab Tests	15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	No Charge	10% Coinsurance (After Deductible)
Advanced Imaging (MRI/PET/CAT Scans)	15% 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	No Charge	10% Coinsurance (After Deductible)
Inpatient Hospital Services						
Inpatient Hospitalization	15%[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	$250 Copay (Per Admission)	10% Coinsurance (After Deductible)
Outpatient Services						
Outpatient Surgery	15%[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	$30 Copay (Per Procedure)	10% Coinsurance (After Deductible)
Outpatient Lab and Imaging	15%[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	No Charge	10% Coinsurance (After Deductible)
Emergency Services						
Ambulance Services	15% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		$50 Copay (Per Trip)	10% Coinsurance (After Deductible)
Emergency Room	15% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		$50 Copay (Waived if Admitted)	10% Coinsurance (After Deductible)
Urgent Care						
Urgent Care Visits	15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$30 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 Indemnity IV PPO: 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).

CSEBO MEDICAL INSURANCE
HEALTH PLAN COMPARISON
EFFECTIVE 1/1/2024 – 12/31/2024

CARRIER	ANTHEM BLUE CROSS				KAISER PERMANENTE	
PLAN NAME	INDEMNITY IV PPO		CDHP PPO 90		HMO 30	CDHP HMO $1,600
Mental Health and Substance Abuse	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
Inpatient Mental Health	15%[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	$250 Copay (Per Admission)	10% Coinsurance (After Deductible)
Outpatient Mental Health Office Visit	15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	$30 Copay	10% Coinsurance (After Deductible)
Other Outpatient Health Services	15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	No Charge	10% Coinsurance (After Deductible)
Other Services						
Acupuncture	15% Coinsurance (After Deductible), Maximum of 18 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible)	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%	$10 Copay, Combined 30 Visits per 12-Month Period for Acupuncure and Chiropractic Services, Referral Not Required	N/A
Chiropractor Services	$20 Copay (Deductible Waived), 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%	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%	$10 Copay, Combined 30 Visits per 12-Month Period for Acupuncure and Chiropractic Services, Referral Not Required	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		$30 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	$4,600/$4,600/$9,200[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 3-Tier	CA Commercial 3-Tier
Retail	**30-Day Supply**		**30-Day Supply**		**30-Day Supply**	**30-Day Supply**
Generic	$20 Copay (Deductible Waived)	Paper Claim Submission Required	$10 Copay (After Deductible)	Paper Claim Submission Required	$15 Copay	$10 Copay (After Deductible)
Brand (Formulary/Preferred)	$30 Copay (Deductible Waived), or 20% Coinsurance, Whichever Greater		$30 Copay (After Deductible)		$30 Copay	$20 Copay (After Deductible)
Brand (Non-Formulary/Non-Preferred)	$50 Copay (Deductible Waived), or 35% Coinsurance, Whichever Greater		$30 Copay (After Deductible)		$30 Copay	$35 Copay (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	Same as Retail Brand		20% Coinsurance (After Deductible; Not to Exceed $150)		50% Coinsurance (Not to Exceed $200)	20% Coinsurance (After Deductible; Not to Exceed $150)
Mail Order	**90-Day Supply**		**90-Day Supply**		**100-Day Supply**	**100-Day Supply**
Generic	$40 Copay (Deductible Waived)	Paper Claim Submission Required	$20 Copay (After Deductible)	Paper Claim Submission Required	$30 Copay	$20 Copay (After Deductible)
Brand (Formulary/Preferred)	$60 Copay (Deductible Waived)		$60 Copay (After Deductible)		$60 Copay	$60 Copay (After Deductible)
Brand (Non-Formulary/Non-Preferred)	$60 Copay (Deductible Waived)		$60 Copay (After Deductible)		$60 Copay	$60 Copay (After Deductible)
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	$100 Copay (Deductible Waived)		20% Coinsurance (After Deductible; Not to Exceed $150)		$60 Copay	20% Coinsurance (After Deductible; Not to Exceed $150)

[2]For Anthem Indemnity IV PPO: 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.

[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.

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CSEBO DENTAL INSURANCE
DELTA DENTAL PPO
EFFECTIVE 1/1/2024 - 12/31/2024

DELTA DENTAL

PLAN NAME	DELTA DENTAL PPO[1]	
GENERAL PLAN INFORMATION	DELTA DENTAL PPO PROVIDERS[1]	PREMIER & NON-DELTA DENTAL PPO PROVIDERS
Calendar Year Annual Maximum		
	$2,500	$2,500
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%
Diagnostic and Preventive Benefits	**Incentive Level Coverage**	
Prophylaxis (Cleaning) Treatments	Plan Pays 100%; limited to 2 per calendar year[2]	Plan Pays 100%; limited to 2 per calendar year[2]
Oral Examinations	Plan Pays 100%; limited to 2 per calendar year[2]	Plan Pays 100%; limited to 2 per calendar year[2]
Full-Mouth X-Rays	Plan Pays 100%; limited to 1 per 36 months[2]	Plan Pays 100%; limited to 1 per 36 months[2]
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]
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
Fluoride Treatments	Plan Pays 100% limited to 4 per calendar year.[2]	Plan Pays 100% limited to 4 per calendar year.[2]
Space Maintainers	Plan Pays 100%[2]	Plan Pays 100%[2]
Basic Benefits	**Incentive Level Coverage**	
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
Oral Surgery - Other Surgical Procedures	Plan Pays 50-100% depending on procedure	Plan Pays 50-100% depending on procedure
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
Endodontic Treatments	Plan Pays 70/80/90/100%; limitations apply	Plan Pays 70/80/90/100%; limitations apply

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CSEBO DENTAL INSURANCE
DELTA DENTAL PPO
EFFECTIVE 1/1/2024 - 12/31/2024

DELTA DENTAL

PLAN NAME	DELTA DENTAL PPO[1]	
GENERAL PLAN INFORMATION	DELTA DENTAL PPO PROVIDERS[1]	PREMIER & NON-DELTA DENTAL PPO PROVIDERS
Basic Benefits (continued)	**Incentive Level Coverage**	
Periodontic Treatment	Plan Pays 70/80/90/100%; limitations apply	Plan Pays 70/80/90/100%; limitations apply
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.
Crowns, Inlays, Onlays and Cast Restoration Benefits	**Incentive Level Coverage**	
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
Prosthodontic Benefits	**Incentive Level Coverage**	
Implants	Plan Pays 50%; limited to once every 5 years	Plan Pays 50%; limited to once every 5 years
Removable - Partial Dentures, Full Dentures	Plan Pays 50%; limited to once every 5 years	Plan Pays 50%; limited to once every 5 years
Fixed - Inlays, Onlays, Bridges	Plan Pays 50%; limited to once every 5 years	Plan Pays 50%; limited to once every 5 years
Nightguards	**Incentive Level Coverage**	
Coverage Percentage	Plan Pays 50%; limited to once per lifetime	Plan Pays 50%; limited to once per lifetime
Lifetime Individual Maximum	$500	$500
Orthodontia Benefits	**Incentive Level Coverage**	
Coverage Eligibility	Adults and Children	Adults and Children
Coverage Percentage	50%	50%
Lifetime Individual Maximum	$3,000	$3,000

[1]Reimbursement 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.

[2]2 cleanings, Exams and X-ray costs do not count towards the calendar year annual maximum.

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CSEBO VISION INSURANCE
PPO COMPARISON
EFFECTIVE 1/1/2024 - 12/31/2024

vsp vision care

GENERAL PLAN INFORMATION	BASE		ENHANCED 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
Prescription Glasses				
Coverage	Contacts **OR** Glasses		Contacts **AND** Glasses	
Frame Allowance	$150	Up To $70	$250	Up To $70
Elective Contact Allowance	$150	Up To $90	$250	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
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	$31 - $35	Provider Rate	$31 - $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

[1]Costco Optical pricing already includes member savings.

[2]Costco Optical pricing may vary.

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EMPLOYEE ASSISTANCE PROGRAM
OPTUM
EFFECTIVE 1/1/2024 - 12/31/2024

TYPE OF PLAN GENERAL PLAN INFORMATION	EMPLOYEE ASSISTANCE PROGRAM[1] 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	No Charge
Covered Visits [2]	**Copays/Coinsurance**
Child/Parenting Services	No Charge
Adult/Elder Support	No Charge
Financial Resources	No Charge
Legal/Mediation Resources	No Charge
Chronic Condition Support	No Charge
Life Learning/Educational Support Services	No Charge
Convenience Services	No Charge

[1]The Employee Assistance Program is a benefit that is provided to each benefit-eligible employee of HESD 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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