

Hacienda La Puente Unified School District

Summary of Anthem HMO 20, HMO 30 and DHMO 500 Select Plan Comparison - Eligible Employees

| Effective Date | 07/01/2024 | 07/01/2024 | 07/01/2024 |
|--|---|---|---|
| Renewal Date | 07/01/2025 | 07/01/2025 | 07/01/2025 |
| Carrier | Anthem Blue Cross | | |
| Plan Name | HMO 20 - \$15/40/80 Rx | HMO 30 - \$15/40/80 Rx | DHMO 500 Select - \$15/40/80 Rx |
| Eligible Class | Eligible Employees | | |
| General Plan Information | | | |
| Annual Deductible/Individual | \$0 | \$0 | \$500 |
| Annual Deductible/Family | \$0 | \$0 | \$1,000 |
| Coinsurance | 100% | 100% | 100% |
| Office Visit/Exam | \$20 copay | \$30 copay | \$40 copay |
| Outpatient Specialist Visit | \$20 copay | \$30 copay | \$40 copay |
| Annual Out-of-Pocket Limit/Individual | \$500 Rx not included | \$500 Rx not included | \$1,500 Rx not included |
| Annual Out-of-Pocket Limit/Family | \$1,500 Rx not included | \$1,500 Rx not included | \$4,500 Rx not included |
| Deductible Included in Out-of-Pocket Limits | N/A | N/A | Yes |
| Lifetime Plan Maximum | Unlimited | Unlimited | Unlimited |
| Primary Care Physician Election Required | Yes | Yes | Yes |
| Outpatient Services | | | |
| Preventive Services | | | |
| Well-Child Care | 100% | 100% | 100% |
| Immunizations | 100% | 100% | 100% |
| Well Woman Exams | 100% | 100% | 100% |
| Mammograms | 100% | 100% | 100% |
| Adult Periodic Exams with Preventive Tests | 100% | 100% | 100% |
| Diagnostic X-Ray and Lab Tests | 100% \$20 copay for CT/SPECT/PET/MRA/MRI | 100% \$30 copay for CT/SPECT/PET/MRA/MRI | 100% \$40 copay for CT/SPECT/PET/MRA/MRI |
| Maternity Care | | | |
| Pregnancy and Maternity Care (Pre-Natal Care) | \$20 copay | \$30 copay | \$40 copay |
| Inpatient Hospital Services | | | |
| Inpatient Hospitalization | 100% | 100% | \$250 admit fee after deductible is met |
| Pre-Authorization of Services Required | Yes | Yes | Yes |
| Semi-Private Room & Board; Including Services and Supplies | 100% | 100% | 100% |
| Surgical Services | | | |
| Outpatient Facility Charge | 100% | 100% | 100% after \$250 copay per admit after deductible has been met |
| Emergency Services | | | |
| Emergency Room | \$100 copay waived if admitted | \$100 copay waived if admitted | \$100 copay waived if admitted |
| Ambulance | | | |
| Air | 100% | 100% | 100% |
| Ground | 100% | 100% | 100% |
| Urgent Care | | | |
| Urgent Care Facility | \$20 copay | \$30 copay | \$40 copay |
| Mental Health Benefits | | | |
| Inpatient Care | 100% (subject to utilization review; waived for emergency admissions) | 100% (subject to utilization review; waived for emergency admissions) | 100% (subject to utilization review; waived for emergency admissions) |

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| Eligible Class | Eligible Employees | | |
| Outpatient Care | 100% (Behavioral Health treatment for autism or pervasive development disorders require pre-service review.) | 100% (Behavioral Health treatment for autism or pervasive development disorders require pre-service review.) | 100% (Behavioral Health treatment for autism or pervasive development disorders require pre-service review.) |
| Substance Abuse | | | |
| Inpatient Care | | | |
| Inpatient Hospitalization | 100% (subject to utilization review; waived for emergency admissions) | 100% (subject to utilization review; waived for emergency admissions) | 100% (subject to utilization review; waived for emergency admissions) |
| Inpatient Detoxification Services | 100% (subject to utilization review; waived for emergency admissions) | 100% (subject to utilization review; waived for emergency admissions) | 100% (subject to utilization review; waived for emergency admissions) |
| Outpatient Care | | | |
| Outpatient Services | 100% | 100% | 100% |
| Prescription Drug Benefits | | | |
| Prescription Drug Annual Out-of-Pocket Limit/Individual | \$1,000 | \$1,000 | \$1,000 |
| Prescription Drug Annual Out-of-Pocket Limit/Family | \$3,000 | \$3,000 | \$3,000 |
| Generic | \$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies) | \$15 copay/Tier 1 Pharmacy \$15 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies) | \$15 copay/Tier 1 Pharmacy \$15 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies) |
| Brand (Non-Formulary/Non-preferred) | \$40 copay/Tier 1 Pharmacy \$40 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies) | \$40 copay/Tier 1 Pharmacy \$40 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies) | \$40 copay/Tier 1 Pharmacy \$40 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies) |
| Number of Days Supply | 30 days | 30 days | 30 days |
| Mail Order | | | |
| Generic | \$30 copay provided by Express Scripts | \$30 copay provided by Express Scripts | \$30 copay provided by Express Scripts |
| Brand (Formulary/Preferred) | \$80 copay provided by Express Scripts | \$80 copay provided by Express Scripts | \$80 copay provided by Express Scripts |
| Brand (Non-Formulary/Non-preferred) | \$160 copay provided by Express | \$160 copay provided by Express | \$160 copay provided by Express |
| Number of Days Supply for Mail Order | 90 days | 90 days | 90 days |
| Other Services and Supplies | | | |
| Durable Medical Equipment & Prosthetic Devices | 100% | 100% | 100% |
| Home Health Care | 100% limited to 100 visits/calendar year; one visit equals four hours or less | 100% limited to 100 visits/calendar year; one visit equals four hours or less | 100% limited to 100 visits/calendar year; one visit equals four hours or less |
| Skilled Nursing or Extended Care Facility | 100% limited to 100 days/calendar year | 100% limited to 100 days/calendar year | 100% limited to 100 days/calendar year |
| Hospice Care | 100% | 100% | 100% |
| Chiropractic Services | Not covered | Not covered | Not covered |
| Acupuncture | \$20 copay; when approved by your medical group | \$30 copay when approved by your medical group | \$40 copay when approved by your medical group |
| Vision | | | |

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| Eligible Class | Eligible Employees | Eligible Employees | Eligible Employees |
| Copay | | | |
| Examination | 100% | 100% | 100% |
| Materials | Not covered | Not covered | Not covered |
| Benefit Frequency | | | |
| Examination | Once every 12 months | Once every 12 months | Once every 12 months |

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| Eligible Class | Eligible Employees | Eligible Employees | Eligible Employees |
| Hearing | | | |
| Screening | 100% | 100% | 100% |
| Aid(s) | 100% limited to one hearing aid per ear every 3 years | 100% limited to one hearing aid per ear every 3 years | 100% limited to one hearing aid per ear every 3 years |
| Infertility | | | |
| Diagnosis | See plan certificate | See plan certificate | See plan certificate |
| Treatment | See plan certificate | See plan certificate | See plan certificate |
| Outpatient Rehabilitative Therapy Services | | | |
| Physical | 100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined | 100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined | 100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined |
| Occupational | 100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined | 100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined | 100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined |
| Speech | 100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined | 100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined | 100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined |