Hacienda La Puente Unified School District

Summary of Anthem PPO Essentials, HSA 1600, and High Performance Network EPO 5900 - Eligible Employees

Effective Date	07/01/2024		07/01/2024		07/01/2024
Renewal Date			07/01	1/2025	07/01/2025
Carrier		Blue Cross		Blue Cross	NEW Anthem Blue Cross
Plan Name	PPO Essentials - \$15/50/15 Rx + Cost			- \$10/30 Rx	Anthem High Performance Network EPO 5900 -
					\$19/\$50/\$75 Rx
Eligible Class		mployees		Employees	Eligible Employees
	In-Network	Out-of-Network	In-Network	Out-of-Network	Schedule of Benefits
General Plan Information Annual Deductible/Individual	\$1,250	\$1,250	¢1.600	¢1.600	\$5,900
Annuar Deductible/ Individuar	\$1,250	\$1,230	\$1,600 medical/prescription/MH- SA in/out of network	\$1,600 medical/prescription/MH- SA in/out of network	\$2,300
Annual Deductible/Family	\$3,750	\$3,750	\$3,200	\$3,200	\$11,800
			medical/prescription/MH- SA in/out of network	medical/prescription/MH- SA in/out of network	
Coinsurance	70%	50%	90%	70%	
Office Visit/Exam	\$40 copay; deductible waived	50%	90%	70%	\$35 copay first 3 visits (deductible waived) then 100% after deductible is met
Outpatient Specialist Visit	\$40 copay; deductible waived	50%	90%	70%	\$35 copay first 3 visits (deductible waived) then 100% after deductible is met
Annual Out-of-Pocket Limit/Individual	\$3,000 Rx not included	\$6,000 Rx not included	\$3,000	\$9,000	\$6,100
Annual Out-of-Pocket Limit/Family	\$9,000 Rx not included	\$18,000 Rx not included	\$6,000	\$18,000	\$12,200
Deductible Included in Out-of-Pocket Limits	Yes	Yes	Yes	Yes	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
High Deductible Health Plan	NI / A			51 / A	N/A
Primary Care Physician Election Required	N/A	N/A	N/A	N/A	0
Outpatient Services Preventive Services					
Well-Child Care	100% deductible waived	50% limited to \$20/exam	100% deductible waived	Not covered	100%
Immunizations	100% deductible waived	50% limited to \$0% limited to \$12/immunization	100% deductible waived	Not covered	100%
Well Woman Exams	100% deductible waived	50% deductible waived	100% deductible waived	Not covered	100%
Mammograms	100% deductible waived	50% deductible waived	100% deductible waived	Not covered	100%
Adult Periodic Exams with Preventive Tests	100% deductible	Not covered	100% deductible waived	Not covered	100%
Diagnostic X-Ray and Lab Tests	70%	50%	90%	70%	100% after deductible is met
Maternity Care					
Pregnancy and Maternity Care (Pre-Natal Care)	\$40/Visit; deductible waived	50%	90%	70%	\$35 copay first 3 visits (deductible waived) then 100% after deductible is met
Inpatient Hospital Services	70~		0.07		
Inpatient Hospitalization	70%	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	90%	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	100% after deductible is met
Pre-Authorization of Services Required	Yes	Yes; If not pre-certified, penalty is \$250 per admission (waived for emergency)	Yes	Yes. If not pre-certified, penalty is \$500 per admission (waived for emergency)	Yes
Semi-Private Room & Board; Including Services and Supplies	70%	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	90%	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	100% after deductible is met
Surgical Services		50~ 1	007		
Outpatient Facility Charge Emergency Services	70%	50% limited to	90%	70% limited to \$350/admit	100% after deductible is met
Emergency Room	70%	70%	90%	90%	100% after deductible is met; in and out of network

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Keenan & Associates CA License # 0451271 4/25/2024 | Page 1 of 4



Hacienda La Puente Unified School District

Summary of Anthem PPO Essentials, HSA 1600, and High Performance Network EPO 5900 - Eligible Employees

Effective Date	07/01	07/01/2024 07/01/2025 Anthem Blue Cross PPO Essentials - \$15/50/15 Rx + Cost		/2024	07/01/2024
Renewal Date	07/01			/2025	07/01/2025
Carrier	Anthem E			Blue Cross	NEW Anthem Blue Cross
Plan Name	PPO Essentials - \$1			\$10/30 Rx	Anthem High Performance Network EPO 5900 - \$19/\$50/\$75 Rx
Eligible Class	Eligible E	Eligible Employees		mployees	Eligible Employees
	In-Network	Out-of-Network	In-Network	Out-of-Network	Schedule of Benefits
Air			90% non-medical emergency is subject to pre-		100% after deductible is met; in and out of network
Ground	service review 70% non-medical emergency is subject to pre- service review	service review; limited to 70% non-medical emergency is subject to pre- service review; limited to	service review 90% non-medical emergency is subject to pre- service review	service review: limited to 90% non-medical emergency is subject to pre- service review: limited to	100% after deductible is met; in and out of network
Urgent Care					
Urgent Care Facility	\$40 copay; deductible	50%	90%	70%	100% after deductible is met; in and out of network
Mental Health Benefits Inpatient Care	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	90% (subject to utilization review; waived for emergency admissions)	70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained	100% after deductible is met
Outpatient Care	\$40 copay; deductible waived (Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)	50%	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre- service review	100% after deductible is met
Substance Abuse					
Inpatient Care	7044				
Inpatient Hospitalization	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	90% (subject to utilization review; waived for emergency admissions)	70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained	100% after deductible is met
Inpatient Detoxification Services	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	90% (subject to utilization review; waived for emergency admissions)	70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained	100% after deductible is met
Outpatient Care		FOM	00%	70%	1000 often deductible is much
Outpatient Services Prescription Drug Benefits	\$40 copay; deductible	50%	90%	70%	100% after deductible is met
Prescription Drug Deductible	N/A	N/A	\$1,600 ind/\$3200 fam medical/prescription/MH- SA in/out of network	\$1,600 ind/\$3200 fam medical/prescription/MH- SA in/out of network	
Prescription Drug Annual Out-of-Pocket	\$1,000	\$1,000	S. CHIP OUT OF HOUNDIN		\$500
Prescription Drug Annual Out-of-Pocket Limit	/Family \$3,000	\$3,000			\$1,000

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Keenan & Associates CA License # 0451271 4/25/2024 | Page 2 of 4



Hacienda La Puente Unified School District

Summary of Anthem PPO Essentials, HSA 1600, and High Performance Network EPO 5900 - Eligible Employees

Effective Date	07/01	/2024	07/01/2024 07/01/2025		07/01/2024
Renewal Date	07/01	/2025			07/01/2025
Carrier	Anthem Blue Cross PPO Essentials - \$15/50/15 Rx + Cost		Anthem Blue Cross HSA 1600 - \$10/30 Rx		NEW Anthem Blue Cross Anthem High Performance Network EPO 5900 - \$19/\$50/\$75 Rx
Plan Name					
Eligible Class	Eligible Employees		Eligible Employees		Eligible Employees
	In-Network	Out-of-Network	In-Network	Out-of-Network	Schedule of Benefits
Generic	\$15 copay/Tier Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express- scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express- scripts.com for a list of pharmacies)	\$10 after deductible Tier 1 Pharmacy \$10 copay after deductible + \$15/Tier 2 Pharmacy provided by ESI (see www.express- scripts.com for a list of	50% after deductible + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express- scripts.com for a list of	\$19 copay/Tier 1 Pharmacy; \$19 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)
Brand (Formulary/Preferred)	\$50 copay/Tier 1 Pharmacy; \$50 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express- scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express- scripts.com for a list of pharmacies)	nharmacies) \$30 after deductible /Tier 1 Pharmacy \$30 copay after deductible + \$15/Tier 2 Pharmacy provided by ESI (see www.express- scripts.com for a list of pharmacies)	nharmacies) 50% after deductible + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express- scripts.com for a list of pharmacies)	\$50 copay/Tier 1 Pharmacy \$50 copay +\$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)
Brand (Non-Formulary/Non-preferred)	\$15 copay + \$15/Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available; (see www.express- scripts.com for a list of	www.express-scripts.com for			\$75 copay/Tier 1 Pharmacy \$75 copay +\$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)
Number of Days Supply	<u>nharmacies)</u> 30 days	a list of pharmacies) 30 days	30 days	30 days	30 days
Mail Order	50 days	50 days	50 days	50 days	
Generic	\$30 copay provided by Express Scripts	Not covered	\$20 copay after deductible; provided by Express Scripts	Not covered	\$38 copay provided by Express Scripts
Brand (Formulary/Preferred)	\$100 copay provided by Express Scripts	Not covered	\$60 copay after deductible; provided by Express Scripts	Not covered	\$100 copay provided by Express Scripts
Brand (Non-Formulary/Non-preferred)	\$30 copay plus cost difference between generic and brand when generic equivalent is available; provided by Express Scripts	Not covered			\$150 copay provided by Express Scripts
Number of Days Supply for Mail Order	90 days		90 days		90 days
Other Services and Supplies	500	500	90%	70%	E007 ofter deductible is mot
Durable Medical Equipment & Prosthetic Devices Home Health Care	50% 70% limited to 100 visits/calendar year; one visit equals four hours or less; in/out of network combined	50% 50% limited to 100 visits/calendar year; one visit equals four hours or less; in/out of network combined	90% 90% limited to 100 visits/calendar year; one visit equals four hours or less; in/out of network combined	70% 70% limited to 100 visits/calendar year; one visit equals four hours or less; in/out of network combined	50% after deductible is met 100% after deductible is met; limited to 100 visits per benefit period
Skilled Nursing or Extended Care Facility	70% limited to 100 days/calendar year; in/out- of-network combined	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency): limited to 100	90% limited to 100 days/calendar year; in/out of network combined	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency): limited to 100	100% after deductible is met; inpatient rehabilitation and skilled nursing services limited to 100 days combined per benefit period

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Keenan & Associates CA License # 0451271 4/25/2024 | Page 3 of 4



Hacienda La Puente Unified School District

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Effective Date	07/01	07/01/2024		1/2024	07/01/2024
Renewal Date	07/01	07/01/2025 Anthem Blue Cross		1/2025	07/01/2025
Carrier	Anthem I			Blue Cross	NEW Anthem Blue Cross
Plan Name	PPO Essentials · \$15/50/15 Rx + Cost		HSA 1600 - \$10/30 Rx		Anthem High Performance Network EPO 5900
					\$19/\$50/\$75 Rx
Eligible Class	Eligible E	Eligible Employees		Employees	Eligible Employees
	In-Network	Out-of-Network	In-Network	Out-of-Network	Schedule of Benefits
Hospice Care	100% after deductible has	80% after deductible has	100% deductible waived	80% after deductible has	100% after deductible is met
	been satisified	been satisified		been satisfied	
Chiropractic Services	70% limited to 24	50% limited to 24	90% limited to 24	70% limited to 24	\$35 copay first 3 visits (deductible waived) then 100%
	visits/calendar year;	visits/calendar year;	visits/calendar year;	visits/calendar year;	after deductible is met
	chiro/phys/occ therapy	chiro/phys/occ therapy combined: in/out of network	phys/occ/chiro combined; in/out of network combined	phys/occ/chiro combined; in/out of network combined	
	combined, m/out of hetwork	combined, m/out of network	In/out of network combined	Involution network combined	
Acupuncture	70%	50%	90%	70%	\$35 copay first 3 visits (deductible waived) then 100%
					after deductible is met
Hearing					
Screening	100%	Not covered	100% Screening included	Not covered	100%
Aids	50% limited to one hearing	50% limited to one hearing	under preventive care 90% limited to one hearing	70% limited to one hearing	100% limited to one hearing aid per ear every 3 year
Alus	aid per ear every three	aid per ear every three	aid per ear every 3 years	aid per ear every 3 years	100 % infinited to one hearing and per ear every 5 year
	years, in/out of network	years, in/out of network	ald per car every 5 years	ald per car every 5 years	
	combined	combined			
Infertility					
Diagnosis	See plan certificate	See plan certificate	See plan certificate	See plan certificate	See plan certificate
Treatment	See plan certificate	See plan certificate	See plan certificate	See plan certificate	See plan certificate
Outpatient Rehabilitative Therapy Services					
Physical	70% Up to 24	50% Up to 24	90% limited to 24	70% limited to 24	\$35 copay first 3 visits (deductible waived) then 100%
	visits/calendar year;	visits/calendar year;	visits/calendar year;	visits/calendar year;	after deductible is met; limited to 24 visits per benefit
	chiro/phys/occ therapy	chiro/phys/occ therapy	phys/occ/chiro combined;	phys/occ/chiro combined;	period combined w/manipulation & occupational therapy
		combined: in/out of network			
Occupational	70% Up to 24	50% Up to 24	90% limited to 24	70% limited to 24	\$35 copay first 3 visits (deductible waived) then 100%
	visits/calendar year;	visits/calendar year;	visits/calendar year;	visits/calendar year;	after deductible is met; limited to 24 visits per benefit
	chiro/phys/occ therapy	chiro/phys/occ therapy combined; in/out of network	phys/occ/chiro combined;	phys/occ/chiro combined; in/out of network combined	period combined w/manipulation & occupational therapy
	combined; in/out of network	combined; In/out of network	in/out of network combined	in/out of network combined	
Speech	70% Up to 24	50% Up to 24	90% limited to 24	70% limited to 24	\$35 copay first 3 visits (deductible waived) then 100%
	visits/calendar year;	visits/calendar year;	visits/calendar year;	visits/calendar year;	after deductible is met; limited to 24 visits per benefit
	chiro/phys/occ therapy	chiro/phys/occ therapy	phys/occ/chiro combined;	phys/occ/chiro combined;	period combined w/manipulation & occupational therapy
	combined: in/out of network	combined: in/out of network	in/out of network combined	in/out of network combined	

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Keenan & Associates CA License # 0451271 4/25/2024 | Page 4 of 4