Keenan

RENEWAL 2024

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	07/01/2025		07/01/2025		07/01/2025
Carrier	**Anthem Blue Cross**		**Anthem 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 Employees		Eligible 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 medical/prescription/MH-SA in/out of network	$1,600 medical/prescription/MH-SA in/out of network	$5,900
Annual Deductible/Family	$3,750	$3,750	$3,200 medical/prescription/MH-SA in/out of network	$3,200 medical/prescription/MH-SA in/out of network	$11,800
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					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 $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					
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					
Outpatient Facility Charge	70%	50% limited to	90%	70% limited to $350/admit	100% after deductible is met
Emergency Services					
Emergency Room	70%	70%	90%	90%	100% after deductible is met; in and out of network
Ambulance					

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	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**Schedule of Benefits**
Air	70% non-medical emergency is subject to pre-service review	70% non-medical emergency is subject to pre-service review; limited to	90% non-medical emergency is subject to pre-service review	90% non-medical emergency is subject to pre-service review; limited to	100% after deductible is met; in and out of network
Ground	70% non-medical emergency is subject to pre-service review	70% non-medical emergency is subject to pre-service review; limited to	90% non-medical emergency is subject to pre-service review	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					
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					
Outpatient Services	$40 copay; deductible	50%	90%	70%	100% after deductible is met
Prescription Drug Benefits					
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			$500
Prescription Drug Annual Out-of-Pocket Limit/Family	$3,000	$3,000			$1,000

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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 pharmacies)	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)	$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)	$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)	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/Tier 1 Pharmacy; $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 pharmacies)	50% + an additional $15 fee applies per prescription for a Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available; (see www.express-scripts.com for a list of pharmacies)			$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	30 days	30 days	30 days	30 days	30 days
Mail Order					
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					
Durable Medical Equipment & Prosthetic Devices	50%	50%	90%	70%	50% after deductible is met
Home Health Care	70% limited to 100 visits/calendar year; one visit equals four hours or less; in/out of network combined	50% limited to 100 visits/calendar year; one visit equals four hours or less; in/out of network combined	90% limited to 100 visits/calendar year; one visit equals four hours or less; in/out of network combined	70% limited to 100 visits/calendar year; one visit equals four hours or less; in/out of network combined	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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Eligible Class	Eligible Employees		Eligible Employees		Eligible Employees
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**Schedule of Benefits**
Hospice Care	100% after deductible has been satisified	80% after deductible has been satisified	100% deductible waived	80% after deductible has been satisfied	100% after deductible is met
Chiropractic Services	70% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined	50% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined	90% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined	70% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined	$35 copay first 3 visits (deductible waived) then 100% after deductible is met
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 under preventive care	Not covered	100%
Aids	50% limited to one hearing aid per ear every three years, in/out of network combined	50% limited to one hearing aid per ear every three years, in/out of network combined	90% limited to one hearing aid per ear every 3 years	70% limited to one hearing aid per ear every 3 years	100% limited to one hearing aid per ear every 3 year
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 visits/calendar year; chiro/phys/occ therapy combined; in/out of network	50% Up to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network	90% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined	70% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined	$35 copay first 3 visits (deductible waived) then 100% after deductible is met; limited to 24 visits per benefit period combined w/manipulation & occupational therapy
Occupational	70% Up to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined	50% Up to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined	90% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined	70% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined	$35 copay first 3 visits (deductible waived) then 100% after deductible is met; limited to 24 visits per benefit period combined w/manipulation & occupational therapy
Speech	70% Up to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network	50% Up to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network	90% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined	70% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined	$35 copay first 3 visits (deductible waived) then 100% after deductible is met; limited to 24 visits per benefit period combined w/manipulation & occupational therapy