Keenan

Redlands Unified School District

Anthem PPO Plan Comparison

	Current		Current		Current	
Effective Date	07/01/2025		07/01/2025		07/01/2025	
Renewal Date	07/01/2026		07/01/2026		07/01/2026	
Carrier	**Anthem Blue Cross**		**Anthem Blue Cross**		**Anthem Blue Cross**	
Plan Name	HSA 1650 · $10/30 Rx		HSA 3000 · $10/30 Rx		PPO 500 90/70 · $10/30/10 Rx + Cost	
Benefit Summary	Eligible Employees		Eligible Employees		Eligible Employees	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
General Plan Information						
Annual Deductible/Individual	$1,650 medical/prescription/MH-SA in/out of network combined	$1,650 medical/prescription/MH-SA in/out of network combined	$3,000 medical/prescription/MH-SA in/out of network combined	$3,000 medical/prescription/MH-SA in/out of network combined	$500	$1,000
Annual Deductible/Family	$3,300 medical/prescription/MH-SA in/out of network combined	$3,300 medical/prescription/MH-SA in/out of network combined	$6,000 medical/prescription/MH-SA in/out of network combined; All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.	$6,000 medical/prescription/MH-SA in/out of network combined; All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.	$1,500	$3,000
Coinsurance	90%	70%	90%	70%	90%	70%
Office Visit/Exam	90%	70%	90%	70%	$30/Visit; deductible waived	70%
Outpatient Specialist Visit	90%	70%	90%	70%	$30/Visit; deductible waived	70%
Annual Out-of-Pocket Limit/Individual	$3,000	$9,000	$4,000	$9,000	$3,000 Rx not included	$6,000 Rx not included
Annual Out-of-Pocket Limit/Family	$6,000	$18,000	$8,000 /All individual OOP Maximum amounts will count toward the family OOP Maximum, but an individual will not have to pay more than the individual OOP Maximum amount.	$18,000 /All individual OOP Maximum amounts will count toward the family OOP Maximum, but an individual will not have to pay more than the individual OOP Maximum amount.	$9,000 Rx not included	$18,000 Rx not included
Deductible Included in Out-of-Pocket Limits	Yes	Yes	Yes	Yes	Yes	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimted
High Deductible Health Plan						
Outpatient Services						
Preventive Services						
Well-Child Care	100% deductible waived	Not covered	100% deductible waived	Not covered	100%	70% limited to $20/exam
Immunizations	100% deductible waived	Not covered	100% deductible waived	Not covered	100%	70% limited to $12/immunization
Well Woman Exams	100% deductible waived	Not covered	100% deductible waived	Not covered	100%	70% deductible waived
Mammograms	100% deductible waived	Not covered	100% deductible waived	Not covered	100%	70% deductible waived
Adult Periodic Exams with Preventive Tests	100% deductible waived	Not covered	100% deductible waived	Not covered	100%	Not covered
Diagnostic X-Ray and Lab Tests	90%	70%	90%	70%	90%	70%

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Benefit Summary	Eligible Employees		Eligible Employees		Eligible Employees	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Maternity Care						
Pregnancy and Maternity Care (Pre-Natal Care)	90%	70%	90%	70%	$30/Visit; Deductible waived	70%
Inpatient Hospital Services						
Inpatient Hospitalization	90%	70% 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)	90%	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)
Pre-Authorization of Services Required	Yes	Yes. If not pre-certified, penalty is $500 per admission (waived for emergency)	Yes	Yes. If not pre-certified, penalty is $500 per admission (waived for emergency)	Yes	Yes; If not pre-certified, penalty is $250 per admission (waived for emergency)
Semi-Private Room & Board; Including Services and Supplies	90%	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	90%	70%	90%	70%
Surgical Services						
Outpatient Facility Charge	90%	70% limited to $350/admit	90%	70% limited to $350/admit	90%	70% limited to $350/surgery
Emergency Services						
Emergency Room	90%	90%	90%	90%	90%	90%
Ambulance						
Air	90% non-medical emergency is subject to pre-service review	90% non-medical emergency is subject to pre-service review; limited to $50,000	90% non-medical emergency is subject to pre-service review	90% non-medical emergency is subject to pre-service review; limited to $50,000	90% non-medical emergency is subject to pre-service review	90% non-medical emergency is subject to pre-service review; limited to $50,000
Ground	90% non-medical emergency is subject to pre-service review	90% non-medical emergency is subject to pre-service review; limited to $50,000	90% non-medical emergency is subject to pre-service review	90% non-medical emergency is subject to pre-service review; limited to $50,000	90% non-medical emergency is subject to pre-service review	90% non-medical emergency is subject to pre-service review; limited to $50,000
Urgent Care						
Urgent Care Facility	90%	70%	90%	70%	$30/Visit; deductible waived	70%
Mental Health Benefits						
Inpatient Care	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.	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.	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
Outpatient Care	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.

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	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drug Benefits						
Prescription Drug Deductible	$1,650 ind/$3300 fam medical/prescription/MH-SA in/out of network combined	$1,650 ind/$3300 fam medical/prescription/MH-SA in/out of network combined	$3,000 ind/$6,000 fam medical/prescription/MH-SA in/out of network combined	$3,000 ind/$6,000 fam medical/prescription/MH-SA in/out of network combined		
Prescription Drug Annual Out-of-Pocket Limit/Individual					$1,000	$1,000
Prescription Drug Annual Out-of-Pocket Limit/Family					$3,000	$3,000
Generic	$10 after deductible (see www.express-scripts.com for a list of pharmacies)	50% after deductible (see www.express-scripts.com for a list of pharmacies)	$10 after deductible (see www.express-scripts.com for a list of pharmacies)	50% after deductible (see www.express-scripts.com for a list of pharmacies)	$10 copay (see www.express-scripts.com for a list of pharmacies)	50% provided (see www.express-scripts.com for a list of pharmacies)
Brand (Formulary/Preferred)						
Brand (Non-Formulary/Non-preferred)	$30 after deductible; + cost difference between generic and brand when generic equivalent is available (see www.express-scripts.com for a list of pharmacies)	50% after deductible; + cost difference between generic and brand when generic equivalent is available (see www.express-scripts.com for a list of pharmacies)	$30 after deductible + cost difference between generic and brand when generic equivalent is available (see www.express-scripts.com for a list of pharmacies)	50% after deductible + cost difference between generic and brand when generic equivalent is available (see www.express-scripts.com for a list of pharmacies)	$30 copay + cost difference between generic and brand when generic equivalent is available (see www.express-scripts.com for a list of pharmacies)	50% + cost difference between generic and brand when generic equivalent is available (see www.express-scripts.com for a list of pharmacies)
Number of Days Supply					$10 copay + cost difference between generic and brand when generic equivalent is available (see www.express-scripts.com for a list of pharmacies)	50% + cost difference between generic and brand when generic equivalent is available (see www.express-scripts.com for a list of pharmacies)

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Benefit Summary	Eligible Employees		Eligible Employees		Eligible Employees	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mail Order	30 days	30 days	30 days	30 days	30 days	30 days
Mail Order Mandatory						
Generic						
Brand (Formulary/Preferred)	$20 copay after deductible	Not covered	$20 copay after deductible	Not covered	$20 copay	Not covered
Brand (Non-Formulary/Non-preferred)						
Number of Days Supply for Mail Order	$60 copay after deductible + cost difference between generic and brand when generic equivalent is available	Not covered	$60 copay after deductible + cost difference between generic and brand when generic equivalent is available	Not covered	$60 copay + cost difference between generic and brand when generic equivalent is available	Not covered
Other Services and Supplies						
Durable Medical Equipment & Prosthetic Devices						
Home Health Care						
Skilled Nursing or Extended Care Facility	90%	70%	90%	70%	90%	70%
Hospice Care	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	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	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
Chiropractic Services	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 days/calendar year; in/out of network combined	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 days/calendar year; in/out of network combined	90% limited to 100 days/calendar year; in/out of network combined	70% plus $500 admission fee after the the deductible has been satisfied (waived for emergency); limited to 100 days/calendar year; in/out of network combined
Acupuncture	100% deductible waived	80% after deductible has been satisfied	100% deductible waived	80% after deductible has been satisfied	100% after deductible has been satisfied	80% after deductible has been satisfied