Keenan

Perris Union High School District

Anthem HMO 20, HMO 20 Select, HMO 30, HMO 30 Select & DHMO 500 Select Plans - Classified Employees

RENEWAL 2025

Carrier	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
Plan Name	HMO 20 - $5/25/40 Rx	HMO 20 Select - $5/25/40 Rx	HMO 30 - $10/30/60 Rx	HMO 30 Select - $19/50/75 Rx	DHMO 500 Select - $10/30/60 Rx
General Plan Information					
Annual Deductible/Individual	$0	$0	$0	$0	$500
Annual Deductible/Family	$0	$0	$0	$0	$1,000
Coinsurance	100%	100%	100%	100%	100%
Office Visit/Exam	$20 copay	$20 copay	$30 copay	$30 copay	$40 copay
Outpatient Specialist Visit	$20 copay	$20 copay	$30 copay	$30 copay	$40 copay
Annual Out-of-Pocket Limit/Individual	$500 Rx not included	$500 Rx not included	$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	$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	N/A	N/A	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes	Yes	Yes	Yes
Outpatient Services					
Preventive Services					
Well-Child Care	100%	100%	100%	100%	100%
Immunizations	100%	100%	100%	100%	100%
Well Woman Exams	100%	100%	100%	100%	100%
Mammograms	100%	100%	100%	100%	100%
Adult Periodic Exams with Preventive Tests	100%	100%	100%	100%	100%
Diagnostic X-Ray and Lab Tests	100% $20 copay for CT/SPECT/PET/MRA/MRI	100% $20 copay for CT/SPECT/PET/MRA/MRI	100% $30 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	$20 copay	$30 copay	$30 copay	$40 copay
Inpatient Hospital Services					
Inpatient Hospitalization	100%	100%	100%	100%	$250 admit fee after deductible is met
Pre-Authorization of Services Required	Yes	Yes	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	100%	100%	100%	100%
Surgical Services					
Outpatient Facility Charge	100%	100%	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	$100 copay waived if admitted	$100 copay waived if admitted
Ambulance					
Air	100%	100%	100%	100%	100%
Ground	100%	100%	100%	100%	100%
Urgent Care					
Urgent Care Facility	$20 copay	$20 copay	$30 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)	100% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)
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.)	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)	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)	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%	100%	100%

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RENEWAL 2025

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Plan Name	HMO 20 · $5/25/40 Rx	HMO 20 Select · $5/25/40 Rx	HMO 30 · $10/30/60 Rx	HMO 30 Select · $19/50/75 Rx	DHMO 500 Select · $10/30/60 Rx
Prescription Drug Benefits					
Prescription Drug Annual Out-of-Pocket Limit/Individual	$1,000	$1,000	$1,000	$1,000	$1,000
Prescription Drug Annual Out-of-Pocket Limit/Family	$3,000	$3,000	$3,000	$3,000	$3,000
Generic	$5 copay/Tier 1 Pharmacy; $5 copay + $15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	$5 copay/Tier 1 Pharmacy; $5 copay + $15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	$10 copay/Tier 1 Pharmacy $10 copay + $15/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)	$10 copay/Tier 1 Pharmacy 10 copay +$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)
Brand (Formulary/Preferred)	$25 copay/Tier 1 Pharmacy $25 copay +$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	$25 copay/Tier 1 Pharmacy $25 copay +$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	$30 copay/Tier 1 Pharmacy $30 copay +$15/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)	$30 copay/Tier 1 Pharmacy $30 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)	$60 copay/Tier 1 Pharmacy $60 copay +$15/Tier 2 Pharmacy provided by ESI (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)	$60 copay/Tier 1 Pharmacy $60 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	$10 copay provided by Express Scripts	$10 copay provided by Express Scripts	$20 copay provided by Express Scripts	$38 copay provided by Express Scripts	$20 copay provided by Express Scripts
Brand (Formulary/Preferred)	$50 copay provided by Express Scripts	$50 copay provided by Express Scripts	$60 copay provided by Express Scripts	$100 copay provided by Express Scripts	$60 copay provided by Express Scripts
Brand (Non-Formulary/Non-preferred)	$80 copay provided by Express Scripts	$80 copay provided by Express Scripts	$120 copay provided by Express Scripts	$150 copay provided by Express Scripts	$120 copay provided by Express Scripts
Number of Days Supply for Mail Order	90 days	90 days	90 days	90 days	90 days
Other Services and Supplies					
Durable Medical Equipment & Prosthetic Devices	100%	100%	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	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	100% limited to 100 days/calendar year	100% limited to 100 days/calendar year
Hospice Care	100%	100%	100%	100%	100%
Chiropractic Services	Not covered	Not covered	Not covered	Not covered	Not covered
Acupuncture	$20 copay; when approved by your medical group	$20 copay; when approved by your medical group	$30 copay when approved by your medical group	$30 copay when approved by your medical group	$40 copay when approved by your medical group
Vision					
Copay					
Examination	100%	100%	100%	100%	100%
Benefit Frequency					
Examination	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Hearing					
Screening	100%	100%	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	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	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, Occupational & Speech Therapy	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	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

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