Keenan

RENEWAL 2025

Hacienda-La Puente Unified School District

Summary of Anthem PPO Essentials, HPN 1250 & HPN EPO 5900 Plans - Classified, Certificated, Management & Confidential Employees

Effective Date	07/01/2025		7/1/2025	7/1/2025
Renewal Date	07/01/2026		7/1/2026	7/1/2026
Carrier	**Anthem Blue Cross**		**Anthem Blue Cross**	**Anthem Blue Cross**
Plan Name	PPO Essentials - $15/50/15 Rx + Cost		Anthem HIgh Performance Network EPO 1250 - $19/50/75	Anthem HIgh Performance Network EPO 5900 - $19/$50/$75 Rx
Eligible Class	Eligible Employees		Eligible Employees	Eligible Employees
	In-Network	**Out-of-Network**	**Schedule of Benefits**	**Schedule of Benefits**
General Plan Information				
Annual Deductible/Individual	$1,250	$1,250	$1,250	$5,900
Annual Deductible/Family	$3,750	$3,750	$3,750	$11,800
Coinsurance	70%	50%	70% after deductible is met	
Office Visit/Exam	$40 copay; deductible waived	50%	$40 copay; deductible waived	$35 copay first 3 visits (deductible waived) then 100% after deductible is met
Outpatient Specialist Visit	$40 copay; deductible waived	50%	$40 copay; deductible waived	$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	$6,100
Annual Out-of-Pocket Limit/Family	$9,000 Rx not included	$18,000 Rx not included	$9,000	$12,200
Deductible Included in Out-of-Pocket Limits	Yes	Yes	Yes	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	N/A	N/A	Yes	Yes
Outpatient Services				
Preventive Services				
Well-Child Care	100% deductible waived	50% limited to $20/exam	100%	100%
Immunizations	100% deductible waived	50% limited to $12/immunization	100%	100%
Well Woman Exams	100% deductible waived	50% deductible waived	100%	100%
Mammograms	100% deductible waived	50% deductible waived	100%	100%
Adult Periodic Exams with Preventive Tests	100% deductible	Not covered	100%	100%
Diagnostic X-Ray and Lab Tests	70%	50%	70% after deductible is met	100% after deductible is met
Maternity Care				
Pregnancy and Maternity Care (Pre-Natal Care)	$40/Visit; deductible waived	50%	$40 copay: deductible waived	$35 copay first 3 visits (deductible waived) then 100% after deductible is met

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Eligible Class	Eligible Employees		Eligible Employees	Eligible Employees
	In-Network	**Out-of-Network**	**Schedule of Benefits**	**Schedule of Benefits**
Inpatient Hospital Services				
Inpatient Hospitalization	70%	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	70% after deductible is met	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
Semi-Private Room & Board; Including Services and Supplies	70%	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	70% after deductible is met	100% after deductible is met
Surgical Services				
Outpatient Facility Charge	70%	50% limited to $350/surgery	70% after deductible is met	100% after deductible is met
Emergency Services				
Emergency Room	70%	70%	70% after deductible is met, in and out of network	100% after deductible is met; in and out of network
Ambulance				
Air	70% non-medical emergency is subject to pre-service review	70% non-medical emergency is subject to pre-service review; limited to $50,000	70% after deductible is met, in and out of network	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 $50,000	70% after deductible is met, in and out of network	100% after deductible is met; in and out of network
Urgent Care				
Urgent Care Facility	$40 copay; deductible waived	50%	$40 copay; deductible waived in and out of network	100% after deductible is met; in and out of network

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Eligible Class	Eligible Employees		Eligible Employees	Eligible Employees
	In-Network	**Out-of-Network**	**Schedule of Benefits**	**Schedule of Benefits**
Mental Health Benefits				
Inpatient Care	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	70% after deductible is met	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%	70% after deductible is met	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)	70% after deductible is met	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)	70% after deductible is met	100% after deductible is met
Outpatient Care				
Outpatient Services	$40 copay; deductible waived	50%	70% after deductible is met	100% after deductible is met

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Eligible Class	Eligible Employees		Eligible Employees	Eligible Employees
	In-Network	**Out-of-Network**	**Schedule of Benefits**	**Schedule of Benefits**
Prescription Drug Benefits				
Prescription Drug Annual Out-of-Pocket Limit/Individual	$1,000	$1,000	$1,000	$500
Prescription Drug Annual Out-of-Pocket Limit/Family	$3,000	$3,000	$3,000	$1,000
Generic	$15 copay provided by Express Scripts (see www.express-scripts.com for a list of pharmacies)	50% provided by Express Scripts (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)	$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 + cost difference between generic and brand when generic equivalent is available; provided by Express Scripts (see www.express-scripts.com for a list of pharmacies)	50% + cost difference between generic and brand when generic equivalent is available; provided by Express Scripts(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)	$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 + cost difference between generic and brand when generic equivalent is available; provided by Express Scripts (see www.express-scripts.com for a list of pharmacies)	50% + cost difference between generic and brand when generic equivalent is available; provided by Express Scripts (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)	$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
Mail Order				
Generic	$30 copay provided by Express Scripts	Not covered	$38 copay provided by Express Scripts	$38 copay provided by Express Scripts
Brand (Formulary/Preferred)	$100 copay + cost difference between generic and brand when generic equivalent is available; provided by Express Scripts	Not covered	$100 copay provided by Express Scripts	$100 copay provided by Express Scripts
Brand (Non-Formulary/Non-preferred)	$30 copay + cost difference between generic and brand when generic equivalent is available; provided by Express Scripts	Not covered	$150 copay provided by Express Scripts	$150 copay provided by Express Scripts
Number of Days Supply for Mail Order	90 days	N/A	90 days	90 days

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Eligible Class	Eligible Employees		Eligible Employees	Eligible Employees
	In-Network	**Out-of-Network**	**Schedule of Benefits**	**Schedule of Benefits**
Other Services and Supplies				
Durable Medical Equipment & Prosthetic Devices	50%	50%	50% after deductible is met	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	70% after deductible is met; limited to 100 visits per benefit period	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 days/calendar year; in/out of network combined	70% after deductible is met; limited to 100 days combined inpatient rehabilitation and skilled nursing services per benefit period	100% after deductible is met; inpatient rehabilitation and skilled nursing services limited to 100 days combined per benefit period
Hospice Care	100% after deductible has been satisified	80% after deductible has been satisified	100% after deductible is met	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	70% Coverage is limited to 24 visits/benefit period for physical/occupational and manipulative treatment combined	$35 copay first 3 visits (deductible waived) then 100% after deductible is met
Acupuncture	70%	50%	70% after deductible is met	$35 copay first 3 visits (deductible waived) then 100% after deductible is met
Hearing				
Screening	100%	Not covered	100%	100%
Aid(s)	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	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
Treatment	See plan certificate	See plan certificate	See plan certificate	See plan certificate

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Eligible Class	Eligible Employees		Eligible Employees	Eligible Employees
	In-Network	**Out-of-Network**	**Schedule of Benefits**	**Schedule of Benefits**
Outpatient Rehabilitative Therapy Services				
Physical	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	70% after deductible is met; limited to 24 visits per benefit period for physical therapy, occupational therapy, and manipulative treatment 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	70% after deductible is met; limited to 24 visits per benefit period for physical therapy, occupational therapy and manipulative treatment 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%	50%	70% after deductible is met; limited to 24 visits per benefit period for physical therapy, occupational therapy and manipulative treatment 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