

## Coachella Valley Unified - Certificated Anthem HMO Plan Comparison & Summary

**NEW\*\***

2021-2022	Anthem HMO Full Network Premier 10	Anthem HMO Full Network Premier 10	Anthem HMO Select Network Premier 10
<b>MEDICAL - CALENDAR YEAR Deductibles &amp; Maximums</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
Individual/Family Deductibles	\$0/\$0	\$0/\$0	\$0/\$0
Individual/Family Out-of-Pocket (OOP) Max <i>(includes medical deductibles, co-insurance and co-pays)</i>	\$1,000/\$2,000	\$1,000/\$2,000	\$1,000/\$2,000

**PROFESSIONAL SERVICES**

Office Visit (OV); Urgent Care; Specialists co-pay	\$10	\$10	\$10
Prenatal, postnatal office visit co-pay	\$10	\$10	\$10
Scans: CT, CAT, MRI, PET etc.	\$100/test	\$100/test	\$100/test
Diagnostic X-ray & Laboratory Procedures	\$0	\$0	\$0
Infertility (refer to plan document)	50%	50%	50%
Preventive Care (includes physical exams & screenings)	\$0	\$0	\$0

**HOSPITAL & SKILLED NURSING FACILITY SERVICES**

Emergency Room visit (co-pay waived if admitted)	\$100	\$100	\$100
Inpatient Hospital (preauthorization required) - limits may apply	\$0	\$0	\$0
Outpatient Hospital	\$0	\$0	\$0
Surgery, Outpatient (performed in Surgery Center)	\$0	\$0	\$0
Surgery, Outpatient (performed in a Hospital) - limits may apply	\$0	\$0	\$0

**MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT**

<b>INPATIENT:</b> Facility Based Care (preauth required)	\$0	\$0	\$0
<b>OUTPATIENT:</b> Facility Based Care (preauth required)	\$0	\$0	\$0

**OTHER SERVICES**

Ambulance (Ground or Air)	\$100	\$100	\$100
Acupuncture - Limits apply	\$10/30 visits combined w/chiro	\$10/30 visits combined w/chiro	\$10/30 visits combined w/chiro
Chiropractic - Limits apply	\$10/30 visits combined w/acu	\$10/30 visits combined w/acu	\$10/30 visits combined w/acu
Durable Medical Equipment (DME)	0%	0%	0%
Physical and Occupational Therapy - Limits apply	\$10	\$10	\$10
Hearing Aids	50% Coinsurance 1 device per ear/36 months	50% Coinsurance 1 device per ear/36 months	50% Coinsurance 1 device per ear/36 months

**PHARMACY BENEFITS**

	9-35	5-20	5-20
Pharmacy Benefit Manager	Navitus	Navitus	Navitus
Individual/Family Rx Out-of-Pocket (OOP) Max <i>(includes Rx deductibles and co-pays)</i>	\$2,500/\$3,500	\$1,500/\$2,500	\$1,500/\$2,500
Generic co-pay/30 days supply	\$0 at Costco \$9 at Other Network	\$0 at Costco \$5 at Other Network	\$0 at Costco \$5 at Other Network
Brand co-pay/30 days supply	\$35	\$20	\$20
Specialty co-pay/up to 30 days supply	\$35 Must Use Navitus Mail	\$20 Must Use Navitus Mail	\$20 Must Use Navitus Mail
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$90	\$0-\$50	\$0-\$50
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy

This sheet is only a brief summary of In-Network patient costs. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Out-of-Network services may not be covered. Employee cost/payroll deduction, if applicable, can be requested from the district.