

**Manhattan Beach Unified School District
Line Item HMO Benefit Comparison**

	Anthem Blue Cross Custom Premier HMO 15/100% Select HMO	Anthem Blue Cross Custom Premier HMO 10/100% Vivity HMO
Line Items as presented on the current benefits.		
General Features		
Calendar Year Deductible	None	None
Maximum Benefits	Unlimited - Federal Law	Unlimited - Federal Law
Annual Copayment Maximum (3 individual maximum per family)	\$1,000 Individual / \$3,000 per family	\$1,000 Individual / \$3,000 per family
Physician Office Visits	\$15 Copayment	\$10 Copayment
Specialist Office Visits	\$15 Copayment	\$10 Copayment
Hospital Benefits	Paid In Full	Paid In Full
Emergency Room	\$50 Copayment (Waived if admitted)	\$50 Copayment (Waived if admitted)
Urgently Needed Services	\$50 Copayment (Waived if admitted)	\$50 Copayment (Waived if admitted)
Pre-Existing Conditions	All conditions covered, provided they are covered benefits.	All conditions covered, provided they are covered benefits.
Benefits Available While Hospitalized as an Inpatient		
Bone Marrow Transplants	Paid In Full	Paid In Full
Clinical Trials	Paid at negotiated rate. Balance (if any) is the responsibility of the Member. PCP referral required.	Paid at negotiated rate. Balance (if any) is the responsibility of the Member. PCP referral required.
Hospice Services	Paid In Full	Paid In Full
Hospital Benefits	Paid In Full	Paid In Full
Mastectomy/Breast Reconstruction	Paid In Full - Covered by Federal Law	Paid In Full - Covered by Federal Law
Maternity Care	Paid In Full	Paid In Full
Mental Health Services	Paid In Full	Paid In Full
Newborn Care	Paid In Full	Paid In Full
Physician Care	Paid In Full	Paid In Full
Reconstructive Surgery	Paid In Full	Paid In Full
Rehabilitation Care (Including physical, occupational and speech therapy.)	Paid In Full	Paid In Full
Skilled Nursing Facility Care (Up to 100 days per benefit period.)	Paid In Full	Paid In Full
Termination of Pregnancy (medical/medication and surgical)	Paid In Full	Paid In Full

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Benefits Available on an Outpatient Basis		
Allergy Testing/Treatment	\$15 Copayment	\$10 Copayment
Ambulance	Paid In Full	Paid In Full
Clinical Trials	Paid at negotiated rate. Balance (if any) is the responsibility of the Member. PCP referral required.	Paid at negotiated rate. Balance (if any) is the responsibility of the Member. PCP referral required.
Cochlear Implant Devices	Paid In Full*	Paid In Full*
Dental Treatment Anesthesia	\$0 to \$50 Copayment - When medically necessary	\$0 to \$50 Copayment - When medically necessary
Dialysis	\$15 Copayment	\$10 Copayment
Durable Medical Equipment	Paid In Full	Paid In Full
Family Planning (Non-Preventive Care)		
<i>Vasectomy</i>	\$50 Copayment	\$50 Copayment
<i>Depo-Provera Injection</i>	Paid In Full	Paid In Full
<i>Termination of Pregnancy</i>	Paid In Full	Paid In Full
Hearing Aid - Standard	Paid In Full	Paid In Full
Hearing Exam	Paid In Full	Paid In Full
Home Health Care Visits (Up to 100 visits per calendar year)	Paid In Full	Paid In Full
Hospice Services	Paid In Full	Paid In Full
Infertility Services	50% Diagnostic Testing - Does not apply to OOP.	50% Diagnostic Testing - Does not apply to OOP.
Infusion Therapy	Paid In Full	Paid In Full
Injectable Drugs	Paid In Full	Paid In Full
X-Ray and Lab Tests	Paid In Full	Paid In Full
Maternity Care, Tests and Procedures	Paid In Full	Paid In Full
Mental Health Services	Paid In Full	Paid In Full
Outpatient Medical Rehabilitation Therapy	Paid In Full	Paid In Full
Oral Surgery Services	Paid In Full - When medically necessary.	Paid In Full - When medically necessary.
Outpatient Surgery at a participating Free-Standing Outpatient Facility	Paid In Full	Paid In Full
Physician Care	\$15 Copayment	\$10 Copayment

Revised: August 13, 2018 - 3:55 PM

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Preventive Care Services	Paid In Full - Covered by Federal Law	Paid In Full - Covered by Federal Law
Prosthetics and Corrective Appliances	Paid In Full	Paid In Full
Radiation Therapy (Standard & Complex)	Paid In Full	Paid In Full
Radiology Services (Standard & Advanced)	Paid In Full	Paid In Full
Special Footwear	Paid In Full	Paid In Full
Vision Refractions	Not Covered**	Not Covered**
Prescription Drug Benefits - Provided through United Health of California		
Generic	\$10	\$10
Brand Formulary	\$20	\$20
Non-Formulary	\$35	\$35
Specialty Drugs (Tier 4)	\$35	\$35
Brand Name Deductible	None	None
Prescription Calendar Year		
Out-Of-Pocket Maximum	Applied to Medical OOP	Applied to Medical OOP

* Medically necessary surgically implanted hearing devices may be covered under your plan's benefits for p

** Standardly cover a routine vision screening to check the overall health of the eye as part of the member