



Perris Union High School District
Summary of Certificated Anthem PPO 500, MVP & HSA 1 Plans

Effective Date: July 1, 2019

RENEWAL **2019**

Effective Date	07/01/2018		07/01/2019		07/01/2019	
Renewal Date	07/01/2019		07/01/2020		07/01/2020	
Carrier Name	Anthem Blue Cross		Anthem Blue Cross		Anthem Blue Cross	
Plan Name	PPO 500 - \$10/30/10 Rx + Cost		PPO MVP		HSA 1 - \$10/30 Rx	
Eligible Class	Eligible Employees		Eligible Employees		Eligible Employees	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
General Plan Information						
Annual Deductible/Individual	\$500	\$1,000	\$5,900	\$11,800	\$1,500 medical/prescription/MH-SA in/out of network combined	\$1,500 medical/prescription/MH-SA in/out of network combined
Annual Deductible/Family	\$1,500	\$3,000	\$11,800	\$23,600	\$3,000 medical/prescription/MH-SA in/out of network combined	\$3,000 medical/prescription/MH-SA in/out of network combined
Coinsurance	90%	70%	100% after the deductible has been satisfied	50%	90%	70%
Office Visit/Exam	\$30/Visit; deductible waived	70%	\$35 copay; deductible waived first 3 visits/combined services	50%	90%	70%
Outpatient Specialist Visit	\$30/Visit; deductible waived	70%	\$35 copay; deductible waived first 3 visits/combined services	50%	90%	70%
Annual Out-of-Pocket Limit/Individual	\$3,000 Rx not included	\$6,000 Rx not included	\$6,100 Rx not included	\$12,700 Rx not included	\$3,000	\$9,000
Annual Out-of-Pocket Limit/Family	\$9,000 Rx not included	\$18,000 Rx not included	\$12,200 Rx not included	\$25,400 Rx not included	\$6,000	\$18,000
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Inpatient Hospital Services						
Inpatient Hospitalization	90%	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	100% after the deductible has been satisfied	50% 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)
Semi-Private Room & Board; Including Services and Supplies	90%	70%	100% after the deductible has been satisfied	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	90%	70%
Emergency Services						
Emergency Room	90%	90%	100%	100%	90%	90%
Mental Health Benefits						
Inpatient Care	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required	100% after the deductible has been satisfied; subject to utilization review; waived for emergency	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency); subject to utilization review	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required
Outpatient Care	90% prior MHN authorization required	70% prior MHN authorization required	\$35 copay; deductible waived for the first 3 visits/combined services	50%	90% prior MHN authorization required	70% prior MHN authorization required
Alcohol Abuse						
Inpatient Care						
Inpatient Hospitalization	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required	70%	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency).	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required
Inpatient Detoxification Services	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required	70%	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency).	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required
Outpatient Care						
Outpatient Services	90% prior MHN authorization required	70% prior MHN authorization required	\$40 copay; deductible waived	50%	90% prior MHN authorization required	70% prior MHN authorization required
Substance Abuse						
Inpatient Care						
Inpatient Hospitalization	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required	100% after the deductible has been satisfied; subject to utilization review; waived for emergency	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency); subject to utilization review	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required
Inpatient Detoxification Services	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required	100% after deductible has been satisfied; subject to utilization review; waived for emergency	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency); subject to utilization review	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required
Outpatient Care						
Outpatient Services	90% prior MHN authorization required	70% prior MHN authorization required	\$35 copay; deductible waived first 3 visits/combined services	50%	90% prior MHN authorization required	70% prior MHN authorization required
Prescription Drug Benefits						

CONFIDENTIAL: The information in this chart is intended for the exclusive use of the recipient in connection with the recipient's review of this proposal. It is not intended for any other purpose. The information described on this page is only intended to be a summary of your benefits. It does not include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your benefits. If the information on this page conflicts in any way with the SPD, the contract provisions of the appropriate policy or plan document (available through your employer) will prevail.



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Plan Name	PPO 500 - \$10/30/10 Rx + Cost		PPO MVP		HSA 1 - \$10/30 Rx	
Eligible Class	Eligible Employees		Eligible Employees		Eligible Employees	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Prescription Drug Deductible			N/A	N/A	\$1,500 ind/\$3000 fam medical/prescription/MH-SA in/out of network combined	\$1,500 ind/\$3000 fam medical/prescription/MH-SA in/out of network combined
Generic	\$10 copay/Tier 1 Pharmacy \$10 copay +\$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a 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)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$10 after deductible Tier 1 Pharmacy \$10 copay after deductible + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	50% after deductible + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)
Brand (Formulary/Preferred)	\$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% + an additional \$15 fee applies per prescription for a 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)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$30 after deductible /Tier 1 Pharmacy \$30 copay after deductible + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	50% after deductible + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)
Brand (Non-Formulary/Non-preferred)	\$10 copay/Tier 1 Pharmacy \$10 copay +\$15/Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available; (see www.express-scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available; (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)	50% + an additional \$15 fee applies per prescription for a 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	30 days
Mail Order						
Mail Order Mandatory						
Generic	\$20 copay provided by Express Scripts	Not covered	\$38 copay provided by Express Scripts	Not covered	\$20 copay after deductible; provided by Express Scripts	Not covered
Brand (Formulary/Preferred)	\$60 copay provided by Express Scripts	Not covered	\$100 copay provided by Express Scripts	Not covered	\$60 copay after deductible; provided by Express Scripts	Not covered
Brand (Non-Formulary/Non-preferred)	\$20 copay plus cost difference between generic and brand when generic equivalent is available; provided by Express Scripts	Not covered	\$150 copay provided by Express Scripts	Not covered		
Number of Days Supply for Mail Order	90 days	Not covered	90 days	N/A	90 days	Not covered
Other Services and Supplies						
Chiropractic Services	90% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined	70% chiro/phys/occ therapy combined; in/out of network combined	\$35 copay; limited to 24 visits/calendar year; chiro/phys/occ therapy combined; deductible waived first 3 visits/combined services; in/out of network combined	50% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined	90% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined	70% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined