Keenan

Murrieta Valley Unified School District

Summary of PPO Plans

RENEWAL 2024

Effective Date Carrier Plan Name	7/1/2024 **Anthem Blue Cross** PPO HSA1600 - $15/40/80 Rx		7/1/2024 **Anthem Blue Cross** PPO HSA3000 - $15/40/80 Rx		7/1/2024 Anthem Blue Cross PPO MVP - $19/50/75 Rx	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network Benefits**	**Out-of-Network Benefits**
General Plan Information						
Annual Deductible/Individual	$1,600 medical/prescription/MH-SA in/out of network combined	$1,600 medical/prescription/MH-SA in/out of network combined	$3,000 medical/prescription/MH-SA in/out of network combined	$3,000 medical/prescription/MH-SA in/out of network combined	$5,900	$11,800
Annual Deductible/Family	$3,200 medical/prescription/MH-SA in/out of network combined	$3,200 medical/prescription/MH-SA in/out of network combined	$6,000 medical/prescription/MH-SA in/out of network combined	$6,000 medical/prescription/MH-SA in/out of network combined	$11,800	$23,600
Coinsurance	90%	70%	90%	70%	100% after the deductible has been satisfied	50%
Office Visit/Exam	90%	70%	90%	70%	$35 copay; deductible waived first 3 visits/combined	50%
Outpatient Specialist Visit	90%	70%	90%	70%	$35 copay; deductible waived first 3 visits/combined services	50%
Annual Out-of-Pocket Limit/Individual	$3,000	$9,000	$4,000	$9,000	$6,100 Rx not included	$12,700 Rx not included
Annual Out-of-Pocket Limit/Family	$6,000	$18,000	$8,000	$18,000	$12,200 Rx not included	$25,400 Rx not included
Lifetime Plan Maximum	Unlimted	Unlimted	Unlimited	Unlimited	Unlimited	Unlimited
InPatient Hospital						
Inpatient Hospitalization	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been	100% after the deductible has been satisfied	50% plus $500 admission fee after the deductible has been satisfied
Emergency Services						
Emergency Room	90%	90%	90%	90%	100%	100%
Mental Health Benefits						
Inpatient Care	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	100% (subject to utilization review; waived for emergency admissions)	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency)
Outpatient Services	90% after the deductible has been satisfied	70%	90%	70%	$35 copay/visit with deductible waived for the first 3 visits	50%
Substance Abuse/Alcohol Abuse						
Inpatient Hospitalization	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	100% (subject to utilization review; waived for emergency admissions)	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency).
Inpatient Detoxification Services	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	100% (subject to utilization review; waived for emergency admissions)	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency).
Outpatient Services	90% after the deductible has been satisfied	70%	90%	70%	$35 copay/visit with deductible waived for the first 3 visits	50%
Outpatient Detoxification Services	90% after the deductible has been satisfied	70%	90%	70%	$35 copay/visit with deductible waived for the first 3 visits	50%
Prescription Drug Benefits						

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General Plan Information						
Annual Deductible/Individual	$1,600 medical/prescription/MH-SA in/out of network combined	$1,600 medical/prescription/MH-SA in/out of network combined	$3,000 medical/prescription/MH-SA in/out of network combined	$3,000 medical/prescription/MH-SA in/out of network combined	$5,900	$11,800
Annual Deductible/Family	$3,200 medical/prescription/MH-SA in/out of network combined	$3,200 medical/prescription/MH-SA in/out of network combined	$6,000 medical/prescription/MH-SA in/out of network combined	$6,000 medical/prescription/MH-SA in/out of network combined	$11,800	$23,600
Prescription Drug Deductible	$1,600/$3,200 medical/prescription/MH-SA in/out of network combined	$1,600/$3,200 medical/prescription/MH-SA in/out of network combined	$3,000/$6,000 medical/prescription/MH-SA in/out of network combined	$3,000/$6,000 medical/prescription/MH-SA in/out of network combined	N/A	N/A
Generic	$15 copay after deductible/Tier 1 Pharmacy; $15 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)	$15 copay after deductible/Tier 1 Pharmacy; $15 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)
Brand (Formulary/Preferred)	$40 copay after deductible/Tier 1 Pharmacy; $40 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)	$40 copay after deductible/Tier 1 Pharmacy; $40 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)
Brand (Non-Formulary/Non-preferred)	$80 copay after deductble/Tier 1 Pharmacy; $80 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)	$80 copay after deductible/Tier 1 Pharmacy; $80 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)	$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						
Generic	$30 copay after deductible; provided by Express Scripts	Not covered	$30 copay after deductible;	Not covered	$38 copay provided by Express Scripts	Not covered
Brand (Formulary/Preferred)	$80 copay after dedible; provided by Express Scripts	Not covered	$80 copay after deductible;	Not covered	$100 copay provided by Express Scripts	Not covered
Brand (Non-Formulary/Non-preferred)	$160 copay after deductible provided by Express Scripts	Not covered	$160 copay after deductible;	Not covered	$150 copay provided by Express Scripts	Not covered
Number of Days Supply	90 days	Not covered	90 days	Not covered	90 days	Not covered
Other Services and Supplies						
Chiropractic Services	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	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	$35 copay/visit with deductible waived for the first 3 visits; limited to 24 visits per calendar year	50% limited to 24 visits/calendar year

The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.

***Premiums below are based on an 8 hour / 100% Contract employee and Delta Dental PPO per month**

Medical Premium*	**$2,207.04**	**$2,008.20**	**Single**	**Employee & Spouse**
Delta Dental PPO	**$111.79**	**$111.79**	**$446.31**	**$937.25**
Vision	**$16.69**	**$16.69**	**$111.79**	**$111.79**
Group Life	**$7.00**	**$7.00**	**$16.69**	**$16.69**
District Cap	**-$916.67**	**-$916.67**	**$7.00**	**$7.00**
Monthly Employee Cost	**$1,425.85**	**$1,227.01**	**-$916.67**	**-$916.67**
			$0.00	**$156.06**
			Employee & Child(ren)	**Family**
			$803.36	**$1,316.61**
			$111.79	**$111.79**
			$16.69	**$16.69**
			$7.00	**$7.00**
			-$916.67	**-$916.67**
			$22.17	**$535.42**