

Murrieta Valley Unified School District

Summary of PPO Plans

2024

Effective Date Carrier								
Plan Name	7/1/2024 7/1/2024							
Plan Name	//1/2024 Anthem Blue Cross PPO HSA1600 - \$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					III HOINGIN ZOIGING	out of Hollies Zonesine		
Annual	\$1,600 medical/prescription/MH-SA in/out of	\$1.600 modical/proscription/MH	\$2 000 modical/proscription/MH	\$2,000 modical/proceription/MH	\$5,900	\$11.800		
Deductible/Individual	network combined	SA in/out of network combined	SA in/out of network combined		\$5,900	\$11,800		
Annual Deductible/Family			\$6,000 medical/prescription/MH-		\$11,800	\$23,600		
,	network combined	SA in/out of network combined	SA in/out of network combined		\$11,000	Ψ20,000		
Coinsurance	90%	70%	90%	70%	100% after the deductible has	50%		
					been satisfied			
Office Visit/Exam	90%	70%	90%	70%	\$35 copay; deductible waived	50%		
					first 3 visits/combined			
Outpatient Specialist Visit	90%	70%	90%	70%	\$35 copay; deductible waived	50%		
Americal Out of Dealest	Ф0.000	#0.000	# 4.000	#0.000	first 3 visits/combined services \$6,100 Rx not included	\$12.700 Rx not included		
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	\$6,000	\$18.000	\$8,000	\$18,000	\$12,200 Rx not included	\$25.400 Rx not included		
Limit/Family	ψ0,000	\$10,000	ψο,οοο	\$10,000	\$12,200 KX Hot included	\$25,400 PX Hot illoladed		
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	90% after the deductible has	70% plus \$500 admission fee	100% after the deductible has	50% plus \$500 admission fee afte		
inpation riospitalization	30 % after the deductible has been satisfied	after the deductible has been	been satisfied	after the deductible has been	been satisfied	the deductible has been satisfied		
Emergency Services								
Emergency Room	90%	90%	90%	90%	100%	100%		
Mental Health Benefits	5070	3070	3070	0070	10070	10070		
Inpatient Care	90% after the deductible has been satisfied	70% plus \$500 admission fee	90% after the deductible has	70% plus \$500 admission fee	100% (subject to utilization	50% plus \$500 admission fee after		
•		after the deductible has been	been satisfied	after the deductible has been	review; waived for emergency	the deductible has been satisfied		
		satisfied (waived for emergency)		satisfied (waived for emergency)	admissions)	(waived for emergency)		
Outpatient Services	90% after the deductible has been	70%	90%	70%	\$35 copay/visit with deductible	50%		
	satisfied				waived for the first 3 visits			
Substance Abuse/Alcohol Abuse								
Inpatient Hospitalization	90% after the deductible has been satisfied	70% plus \$500 admission fee	90% after the deductible has	70% plus \$500 admission fee	100% (subject to utilization	50% plus \$500 admission fee afte		
padom respitalization	5070 ditor the deduction has been editioned	after the deductible has been	been satisfied	after the deductible has been	review; waived for emergency	the deductible has been satisfied		
		satisfied (waived for emergency)	20011 041101104	satisfied (waived for emergency)	admissions)	(waived for emergency).		
Inpatient Detoxification	90% after the deductible has been satisfied	70% plus \$500 admission fee	90% after the deductible has	70% plus \$500 admission fee	100% (subject to utilization	50% plus \$500 admission fee after		
Services		after the deductible has been	been satisfied	after the deductible has been	review; waived for emergency	the deductible has been satisfied		
		satisfied (waived for emergency)		satisfied (waived for emergency)	admissions)	(waived for emergency).		
Outpatient Services	90% after the deductible has been satisfied	70%	90%	70%	\$35 copay/visit with deductible	50%		
					waived for the first 3 visits			
Outpatient Detoxification	90% after the deductible has been satisfied	70%	90%	70%	\$35 copay/visit with deductible	50%		
Services					waived for the first 3 visits			
Prescription Drug Benefits								



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2024

	Summary of PPO Plans					
Effective Date Carrier						
Plan Name	7/1/2024		7/1/2	7/1/2024		/2024
	Anthem Blue Cross		Anthem Blue Cross		Anthem Blue Cross	
	PPO HSA1600 - \$15/	40/80 Rx	PPO HSA3000	- \$15/40/80 Rx	PPO MVP -	- \$19/50/75 Rx
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Benefits	Out-of-Network Benefit
General Plan Information						
Annual	\$1,600 medical/prescription/MH-SA in/out of	\$1.600 medical/prescription/MH-	\$3,000 medical/prescription/MH-	\$3,000 medical/prescription/MH-	\$5.900	\$11,800
Deductible/Individual	network combined	SA in/out of network combined	SA in/out of network combined	SA in/out of network combined	Ψ5,900	\$11,000
Annual Deductible/Family	\$3,200 medical/prescription/MH-SA in/out of	\$3,200 medical/prescription/MH-	\$6,000 medical/prescription/MH-	\$6,000 medical/prescription/MH-	\$11.800	\$23.600
, iiii aai 2 daadiibidii ai iiiiy	network combined	SA in/out of network combined	SA in/out of network combined	SA in/out of network combined	Ψ11,000	Ψ20,000
Prescription Drug	\$1,600/\$3,200	\$1.600/\$3.200	\$3.000/\$6.000	\$3.000/\$6.000		
Deductible	medical/prescription/MH-SA in/out of	medical/prescription/MH-SA	medical/prescription/MH-SA	medical/prescription/MH-SA	N/A	N/A
Deddedble	network combined	in/out of network combined	in/out of network combined	in/out of network combined	N/A	1974
Generic	\$15 copay after deductible/Tier 1 Pharmacy;	50% + an additional \$15 fee	\$15 copay after deductible/Tier	50% + an additional \$15 fee	\$19 copay/Tier 1 Pharmacy: \$19	50% + an additional \$15 fee appl
Gelenc	\$15 copay + \$15/Tier 2 Pharmacy provided	applies per prescription for a	1 Pharmacy; \$15 copay +	applies per prescription for a	copay	per prescription for a Tier 2
	by ESI (see www.express-scripts.com for a	Tier 2 Pharmacy; provided by	\$15/Tier 2 Pharmacy provided	Tier 2 Pharmacy; provided by	+ \$15/Tier 2 Pharmacy provided	
	list of pharmacies)	ESI (see www.express-	by ESI (see www.express-	ESI (see www.express-	by ESI (see www.express-	www.express- scripts.com for a l
	list of priarriadics)	scripts.com for a list of	scripts.com for a list of	scripts.com for a list of	scripts.com for a list of	of pharmacies)
		pharmacies)	pharmacies)	pharmacies)	pharmacies)	or priarriacios)
Brand	\$40 copay after deductible/Tier 1 Pharmacy;	50% + an additional \$15 fee	\$40 copay after deductible/Tier	50% + an additional \$15 fee		50% + an additional \$15 fee appl
(Formulary/Preferred)	\$40 copay + \$15/Tier 2 Pharmacy provided	applies per prescription for a	1 Pharmacy; \$40 copay +	applies per prescription for a	copay	per prescription for a Tier 2
(Torridiary/Freierred)	by ESI (see www.express-scripts.com for a	Tier 2 Pharmacy; provided by	\$15/Tier 2 Pharmacy provided	Tier 2 Pharmacy; provided by	+ \$15/Tier 2 Pharmacy provided	
	list	ESI (see www.express-	by ESI (see www.express-	ESI (see www.express-	by ESI (see www.express-	www.express- scripts.com for a l
	of pharmacies)	scripts.com for a list	scripts.com for a list	scripts.com for a list of	scripts.com for a list of	of pharmacies)
	or priamiasiss)	of pharmacies)	of pharmacies)	pharmacies)	pharmacies)	5. p.naas.55)
Brand (Non-Formulary/Non-	\$80 copay after deductble/Tier 1 Pharmacy;	50% + an additional \$15 fee	\$80 copay after deductible/Tier	50% + an additional \$15 fee		50% + an additional \$15 fee appl
preferred)	\$80 copay + \$15/Tier 2 Pharmacy provided	applies per prescription for a	1 Pharmacy; \$80 copay +	applies per prescription for a	copay	per prescription for a Tier 2
p. c. c cu)	by ESI (see www.express-scripts.com for a	Tier 2 Pharmacy; provided by	\$15/Tier 2 Pharmacy provided	Tier 2 Pharmacy; provided by	+ \$15/Tier 2 Pharmacy provided	
	list of pharmacies)	ESI (see www.express-	by ESI (see www.express-	ESI (see www.express-	by ESI (see www.express-	www.express- scripts.com for a li
	'	scripts.com for a list of	scripts.com for a list of	scripts.com for a list of	scripts.com for a list of	of pharmacies)
		pharmacies)	pharmacies)	pharmacies)	pharmacies)	
Number of Days Supply	30 days	30 days	30 days	30 days	30 days	30 days
1ail Order						
Generic	\$30 copay after deductible;	Not covered	\$30 copay after	Not covered	\$38 copay provided by Express	Not covered
	provided by Express Scripts		deductible;		Scripts	
Brand (Formulary/Preferred)	\$80 copay after dedible; provided	Not covered	\$80 copay after	Not covered	\$100 copay provided by Express	Not covered
	by Express Scripts		deductible:		Scripts	
Brand (Non-Formulary/Non-	\$160 copay after deductible	Not covered	\$160 copay after	Not covered	\$150 copay provided by Express	Not covered
preferred)	provided by Express Scripts	N	deductible;	N	Scripts	N
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;	70% limited to 24 visits/calendar	90% limited to 24 visits/calendar	70% limited to 24 visits/calendar	\$35 copay/visit with deductible	
	phys/occ/chiro combined;	year; phys/occ/chiro combined;	year; phys/occ/chiro combined;	year; phys/occ/chiro combined;	waived for the first 3 visits;	50% limited to 24 visits/calendar
	in/out of network combined	in/out of network combined	in/out of network combined	in/out of network combined	limited to 24 visits	year
					per calendar year	
The above info	rmation is intended as a benefit summary only.	It does not include all of the benef	it provisions, limitations and qualit	fications. If this information conflic	ts in any way with the contract, the	contract will prevail.
	*Pre	emiums below are based on an 8	hour / 100% Contract employee a	nd Delta Dental PPO per month		
				08.20	Single	Employee & Spouse
Medical Premium*	\$2,207.04	\$111.79		\$111.79		\$937.25
	\$111.79				\$446.31	
Pelta Dental PPO Vision	\$111.79 \$16.69		\$16	5.69	\$111.79	\$111.79
elta Dental PPO ision iroup Life	\$111.79 \$16.69 \$7.00		\$16 \$7	6.69 .00	\$111.79 \$16.69	\$16.69
elta Dental PPO ision iroup Life istrict Cap	\$111.79 \$16.69 \$7.00 -\$916.67		\$16 \$7 -\$91	3.69 .00 6.67	\$111.79 \$16.69 \$7.00	\$16.69 \$7.00
elta Dental PPO lision Group Life District Cap	\$111.79 \$16.69 \$7.00		\$16 \$7 -\$91	6.69 .00	\$111.79 \$16.69 \$7.00 -\$916.67	\$16.69 \$7.00 -\$916.67
Delta Dental PPO Vision Group Life District Cap	\$111.79 \$16.69 \$7.00 -\$916.67		\$16 \$7 -\$91	3.69 .00 6.67	\$111.79 \$16.69 \$7.00 -\$916.67 \$0.00	\$16.69 \$7.00 -\$916.67 \$156.06
elta Dental PPO lision Group Life District Cap	\$111.79 \$16.69 \$7.00 -\$916.67		\$16 \$7 -\$91	3.69 .00 6.67	\$111.79 \$16.69 \$7.00 -\$916.67 \$0.00 Employee & Child(ren)	\$16.69 \$7.00 -\$916.67 \$156.06 Family
elta Dental PPO ision iroup Life istrict Cap lonthly Employee Cost	\$111.79 \$16.69 \$7.00 -\$916.67 \$1,425.85		\$16 \$7 -\$91 \$1,2:	6.69 .00 6.67 27.01	\$111.79 \$16.69 \$7.00 -\$916.67 \$0.00 Employee & Child(ren) \$803.36	\$16.69 \$7.00 -\$916.67 \$15.06 Family \$1,316.61
elta Dental PPO ision ision froup Life district Cap flonthly Employee Cost	\$111.79 \$16.69 \$7.00 -\$916.67 \$1,425.85 ation in this chart is intended for the exclusive use		\$16 \$7 -\$91 \$1,22	6.69 .00 6.67 27.01	\$111.79 \$16.69 \$7.00 -\$916.67 \$0.00 Employee & Child(ren) \$803.36 \$111.79	\$16.69 \$7.00 -\$916.67 \$156.06 Family \$1,316.61 \$111.79
Delta Dental PPO Tision Siroup Life District Cap Monthly Employee Cost CONFIDENTIAL: The information of the control of the co	\$111.79 \$16.69 \$7.00 \$916.67 \$1,425.85 ation in this chart is intended for the exclusive use The information described on this page is only intended for the exclusive use	ended to be a summary of your ben	\$16 \$7 -\$91 \$1,2: the recipient's review of this proposa efits. It does not include all benefit	6.69 .00 6.67 27.01 I. It is not provisions,	\$111.79 \$16.69 \$7.00 -\$916.67 \$0.00 Employee & Child(ren) \$803.36 \$111.79 \$16.69	\$16.69 \$7.00 -\$916.67 \$156.06 Family \$1,316.61 \$111.79 \$16.69
intended for any other purpose. limitations, exclusions, or qualific	\$111.79 \$16.69 \$7.00 -\$916.67 \$1,425.85 ation in this chart is intended for the exclusive use	ended to be a summary of your ben Plan Description (SPD) for a complete	\$16 \$7 -\$91 \$1,22 the recipient's review of this proposa efits. It does not include all benefit te summary of your benefits. If the ir	6.69 .00 6.67 27.01 L. It is not provisions, aformation	\$111.79 \$16.69 \$7.00 -\$916.67 \$0.00 Employee & Child(ren) \$803.36 \$111.79	\$16.69 \$7.00 -\$916.67 \$156.06 Family \$1,316.61 \$111.79