Murrieta Valley Unified School District
2020-2021 Plan Year

Summary of Anthem Blue Cross PPO Plans

Effective Date	07/01/2020		07/01/2020		07/01/2020		07/01/2020	
Renewal Date	07/01/2021		07/01/2021		07/01/2021		07/01/2021	
Carrier Name	**Anthem Blue Cross**		**Anthem Blue Cross**		**Anthem Blue Cross**		**Anthem Blue Cross**	
Plan Name	HSA 1500 - $15/40/80 Rx		HSA 3000 - $15/40/80 Rx		PPO Essentials - $15/50/15 Rx + Cost		PPO MVP	
	In-Network Benefits	**Out-of-Network Benefits**	**In-Network Benefits**	**Out-of-Network Benefits**	**In-Network Benefits**	**Out-of-Network Benefits**	**In-Network Benefits**	**Out-of-Network Benefits**
General Plan Information								
	In-Network Benefits	Out-of-Network Benefits	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	$1,500 medical/prescription/MH-SA in/out of network combined	$1500 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	$1,250	$1,250	$5,900	$11,800
Annual Deductible/Family	$3,000 medical/prescription/MH-SA in/out of network combined; All individual Deductible costs will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.	$3,000 medical/prescription/MH-SA in/out of network combined; All individual Deductible costs will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.	$6,000 medical/prescription/MH-SA in/out of network combined; All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.	$6,000 medical/prescription/MH-SA in/out of network combined; All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.	$3,750	$3,750	$11,800	$23,600
Coinsurance	90%	70%	90%	70%	70%	50%	100% after the deductible has been satisfied	50%
Office Visit/Exam	90%	70%	90%	70%	$40 copay; deductible waived	50%	$35 copay; deductible waived first 3 visits/combined services	50%
Outpatient Specialist Visit	90%	70%	90%	70%	$40 copay; deductible waived	50%	$35 copay; deductible waived first 3 visits/combined services	50%
Annual Out-of-Pocket Limit/Individual	$3,000	$9,000	$4,000	$9,000	$3,000 Rx not included	$6,000 Rx not included	$6,100 Rx not included	$12,700 Rx not included
Annual Out-of-Pocket Limit/Family	$6,000	$18,000	$8,000 /All individual OOP Maximum amounts will count toward the family OOP Maximum, but an individual will not have to pay more than the individual OOP Maximum amount.	$18,000 /All individual OOP Maximum amounts will count toward the family OOP Maximum, but an individual will not have to pay more than the individual OOP Maximum amount.	$6,000	$9,000	$12,200 Rx not included	$25,400 Rx not included
Annual Out-of-Pocket Limit/Individual	$3,000	$9,000	$4,000	$9,000	$3,000 Rx not included	$6,000 Rx not included	$6,100 Rx not included	$12,700 Rx not included
Inpatient Hospital Services								
Inpatient Hospital Services	90%	70% 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)	70%	50% 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)
Emergency Services								
Emergency Room	90%	90%	90%	90%	70%	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	100%	100%
Mental Helath Benefits								
Inpatient Care	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained.	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained.	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)

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Outpatient Care	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.	$40 copay; deductible waived (Behavioral Health treatment for Autism or Pervasive Development disordfers require pre-servuce review)	50%	$35 copay/visit with deductible waived for the first 3 visits (Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)	50%
Substance Abuse								
Inpatient Hospitalization	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained.	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained.	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)
Substance Abuse (Con't)								
Inpatient Detoxification Services	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained.	90%	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained.	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)
Outpatient Care	90%	70%	90%	70%	$40 copay; deductible waived	50%	$35 copay/visit with deductible waived for the first 3 visits	50%
Prescription Drug Benefits								
Prescription Drug Deductible	$1,500 ind/$3,000 fam medical/prescription/MH-SA in/out of network combined	$1,500 ind/$3,000 fam medical/prescription/MH-SA in/out of network combined	$3,000 ind/$6,000 fam medical/prescription/MH-SA in/out of network combined	$3,000 ind/$6,000 fam medical/prescription/MH-SA in/out of network combined	N/A	N/A	N/A	N/A
Prescription Drug Annual Out-of-Pocket Limit/Individual	N/A	N/A	N/A	N/A	$1,500	$1,500	$500	$500
Prescription Drug Annual Out-of-Pocket Limit/Family	N/A	N/A	N/A	N/A	$4,500	$4,500	$1,000	$1,000
Generic	$15 after deductible/ Tier 1 Pharmacy $15 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)	$15 after deductible Tier 1 Pharmacy; $15 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)	$15 copay/Tier 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 after deductible/ Tier 1 Pharmacy $40 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)	$40 after deductible/Tier 1 Pharmacy; $40 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)	$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)	$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)

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Brand (Non-Formulary/Non-preferred)	$80 after deductible/ Tier 1 Pharmacy $80 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 presecription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)	$80 after deductible/ Tier 1 Pharmacy; $80 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 appliese per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)	$15 copay/Tier 1 Pharmacy; $15 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	30 days	30 days
Mail Order								
Generic	$30 copay after deductible; provided by Express Scripts	Not covered	$30 copay after deductible; provided by Express Scripts	Not covered	$30 copay provided by Express Scripts	Not covered	$38 copay provided by Express Scripts	Not covered
Brand (Formulary/Preferred)	$80 copay after deductible; provided by Express Scripts	Not covered	$80 copay after deductible; provided by Express Scripts	Not covered	$100 copay provided by Express Scripts	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; provided by Express Scripts	Not covered	$30 copay plus cost difference beteeen generic and brand when generic equivalent is available, provided by Espress Scripts	Not covered	$150 copay provided by Express Scripts	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	70% limited to 24 wisits/calendar year, chiro/phys/occ therapy combined; in/out of network combined	50% limited to 24 visits/calendar year; 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

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

Medical Premium*							**Single**	**Employee & Spouse**
Delta Dental PPO	**$1,785.55**		**$1,624.70**		**$2,148.60**		**$383.37**	**$805.08**
Vision	**$121.78**		**$121.78**		**$121.78**		**$121.78**	**$121.78**
Group Life	**$16.69**		**$16.69**		**$16.69**		**$16.69**	**$16.69**
District Cap	**$7.00**		**$7.00**		**$7.00**		**$7.00**	**$7.00**
Employee Cost	**-$806.25**		**-$806.25**		**-$806.25**		**-$806.25**	**-$806.25**
	$1,124.77		**$963.92**		**$1,487.82**		**$0.00**	**$144.30**

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

Medical Premium*							**Employee & Child(ren)**	**Family**
Delta Dental PPO							**$690.07**	**$1,130.94**
Vision							**$121.78**	**$121.78**
Group Life							**$16.69**	**$16.69**
District Cap							**$7.00**	**$7.00**
Employee Cost							**-$806.25**	**-$806.25**
							$29.29	**$470.16**

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