Keenan

Alvord Unified School District

REEP Anthem PPO 500 & Anthem HSA $1500 Plan Comparison - Management

RENEWAL 2022

Effective Date: July 1, 2022	07/01/2022		07/01/2022	
Renewal Date	07/01/2023		07/01/2023	
Carrier	**Anthem Blue Cross**		**Anthem Blue Cross**	
Plan Name	PPO 500 90/70 · $15/50/15 Rx + Cost		HSA 1500 · $15/40/80 Rx	
Benefit Summary	Eligible Employees		Eligible Employees	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
General Plan Information				
Annual Deductible/Individual	$500	$1,000	$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	$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%	90%	70%
Office Visit/Exam	$30/Visit; deductible waived	70%	90%	70%
Outpatient Specialist Visit	$30/Visit; deductible waived	70%	90%	70%
Annual Out-of-Pocket Limit/Individual	$3,000 Rx not included	$6,000 Rx not included	$3,000	$9,000
Annual Out-of-Pocket Limit/Family	$9,000 Rx not included	$18,000 Rx not included	$6,000	$18,000
Lifetime Plan Maximum	Unlimited	Unlimted	Unlimited	Unlimited
Inpatient Hospital Services				
Inpatient Hospitalization	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)
Semi-Private Room & Board; Including Services and Supplies	90%	70%	90%	70%
Emergency Services				
Emergency Room	90%	90%	90%	90%
Mental Health 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.
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.
Substance Abuse				
Inpatient Care				
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.

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Benefit Summary	Eligible Employees		Eligible Employees	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
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% (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.
Outpatient Care				
Outpatient Services	90%	70%	90%	70%
Prescription Drug Benefits				
Prescription Drug Deductible			$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	$15 copay/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 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)
Brand (Formulary/Preferred)	$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)	$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)
Brand (Non-Formulary/Non-preferred)	$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)	$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 presecritpion 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
Mail Order				
Generic	$30 copay provided by Express Scripts	Not covered	$30 copay after deductible; provided by Express Scripts	Not covered
Brand (Formulary/Preferred)	$100 copay provided by Express Scripts	Not covered	$80 copay after deductible; provided by Express Scripts	Not covered

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Brand (Non-Formulary/Non-preferred)	$30 copay plus cost difference between generic and brand when generic equivalent is available; provided by Express Scripts	Not covered	$160 copay after deductible; provided by Express Scripts	Not covered
Number of Days Supply for Mail Order	90 days	Not covered	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	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