Keenan & Associates

RENEWAL 2020

Redlands Unified School District

Summary of Anthem PPO Plans

Effective Date	07/01/2020		07/01/2020	
Carrier Name	**Anthem Blue Cross**		**Anthem Blue Cross**	
Plan Name	PPO 500 - $10/30/10 Rx + Cost		PPO 750 - $15/50/15 Rx + Cost	
Eligible Class	Eligible Employees		Eligible Employees	
	In-Network Benefits	**Out-of-Network Benefits**	**In-Network Benefits**	**Out-of-Network Benefits**
General Plan Information				
Annual Deductible/Individual	$500	$1,000	$750	$1,500
Annual Deductible/Family	$1,500	$3,000	$2,250	$4,500
Coinsurance	90%	70%	80%	60%
Office Visit/Exam	$30/Visit; deductible waived	70%	$40/Visit; deductible waived	60%
Outpatient Specialist Visit	$30/Visit; deductible waived	70%	$40/Visit; deductible waived	60%
Annual Out-of-Pocket Limit/Individual	$3,000 Rx not included	$6,000 Rx not included	$3,000 Rx not included	$6,000 Rx not included
Annual Out-of-Pocket Limit/Family	$9,000 Rx not included	$18,000 Rx not included	$9,000 Rx not included	$18,000 Rx not included
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Inpatient Hospital Services				
Inpatient Hospitalization	90%	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	80%	60% plus $500 admission fee after the deductible has been satisfied (waived for emergency)
Semi-Private Room & Board; Including Services and Supplies	90%	70%	80%	60%
Emergency Services				
Emergency Room	90%	90%	80%	80%
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.
Alcohol 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.
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%
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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	In-Network Benefits	**Out-of-Network Benefits**	**In-Network Benefits**	**Out-of-Network Benefits**
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	N/A	N/A	N/A	N/A
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)	$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)
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)
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)	$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)
Number of Days Supply	30 days	30 days	30 days	30 days
Mail Order				
Generic	$20 copay provided by Express Scripts	Not covered	$30 copay 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
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	$30 copay plus cost difference between generic and brand when generic equivalent is available; provided by Express Scripts	Not covered
Number of Days Supply for Mail Order	90 days	Not covered	90 days	N/A
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	80% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined	60% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined