Keenan & Associates

RENEWAL 2020

Redlands Unified School District
Summary of PPO Plans

Effective Date	07/01/2020		07/01/2020	
Carrier Name	**Anthem Blue Cross**		**Anthem Blue Cross**	
Plan Name	HSA 1500 - $10/30 Rx		HSA 3000 - $10/30 Rx	
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	$1,500 medical/prescription/MH-SA in/out of network combined	$1,500 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
Annual Deductible/Family	$3,000 medical/prescription/MH-SA in/out of network combined	$3,000 medical/prescription/MH-SA in/out of network combined	$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.
Coinsurance	90%	70%	90%	70%
Office Visit/Exam	90%	70%	90%	70%
Outpatient Specialist Visit	90%	70%	90%	70%
Annual Out-of-Pocket Limit/Individual	$3,000	$9,000	$4,000	$9,000
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.
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)	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 & Alcohol 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.
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 Services	90%	70%	90%	70%

CONFIDENTIAL: The information in this chart is intended for the exclusive use of the recipient in connection with the recipient's review of this proposal. It is not intended for any other purpose. The information described on this page is only intended to be a summary of your benefits. It does not include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your benefits. If the information on this page conflicts in any way with the SPD, the contract provisions of the appropriate policy or plan document (available through your employer) will prevail.

Keenan & Associates

Redlands Unified School District
Summary of PPO Plans

RENEWAL 2020

Effective Date	07/01/2020		07/01/2020	
Carrier Name	**Anthem Blue Cross**		**Anthem Blue Cross**	
Plan Name	HSA 1500 - $10/30 Rx		HSA 3000 - $10/30 Rx	
Eligible Class	Eligible Employees		Eligible Employees	
	In-Network Benefits	**Out-of-Network Benefits**	**In-Network Benefits**	**Out-of-Network Benefits**
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
Generic	$10 after deductible Tier 1 Pharmacy $10 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)	$10 after deductible Tier 1 Pharmacy; $10 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)	$30 after deductible /Tier 1 Pharmacy $30 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)	$30 after deductible/Tier 1 Pharmacy; $30 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)	$30 after deductible /Tier 1 Pharmacy $30 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)	$30 after deductible /Tier 1 Pharmacy $30 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)
Number of Days Supply	30 days	30 days	30 days	30 days
Mail Order				
Generic	$20 copay after deductible; provided by Express Scripts	Not covered	$20 copay after deductible; provided by Express Scripts	Not covered
Brand (Formulary/Preferred)	$60 copay after deductible; provided by Express Scripts	Not covered	$60 copay after deductible; provided by Express Scripts	Not covered
Brand (Non-Formulary/Non-preferred)	$60 copay after deductible; provided by Express Scripts	Not covered	$60 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; phys/occ/chiro combined; in/out of network	70% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network	90% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network	70% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network

CONFIDENTIAL: The information in this chart is intended for the exclusive use of the recipient in connection with the recipient's review of this proposal. It is not intended for any other purpose. The information described on this page is only intended to be a summary of your benefits. It does not include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your benefits. If the information on this page conflicts in any way with the SPD, the contract provisions of the appropriate policy or plan document (available through your employer) will prevail.