Murrieta Valley Unified School District

Summary of PPO Plans

Keenan RENEWAL 2025

Effective Date	7/1/2025		7/1/2025		7/1/2025	
Carrier	**Anthem Blue Cross**		**Anthem Blue Cross**		Anthem Blue Cross	
Plan Name	PPO HSA 1650 - $15/40/80 Rx		PPO HSA 3000 - $15/40/80 Rx		PPO MVP 5900 - $19/50/75 Rx	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	In-Network Benefits	Out-of-Network Benefits
General Plan Information						
Annual Deductible/Individual	$1,650 medical/prescription/MH-SA in/out of network combined	$1,650 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	$5,900	$11,800
Annual Deductible/Family	$3,300 medical/prescription/MH-SA in/out of network combined	$3,300 medical/prescription/MH-SA in/out of network combined	$6,000 medical/prescription/MH-SA in/out of network combined	$6,000 medical/prescription/MH-SA in/out of network combined	$11,800	$23,600
Coinsurance	90%	70%	90%	70%	100% after the deductible has been satisfied	50%
Office Visit/Exam	90%	70%	90%	70%	$35 copay; deductible waived first 3 visits/combined services	50%
Outpatient Specialist Visit	90%	70%	90%	70%	$35 copay; deductible waived first 3 visits/combined services	50%
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 Limit/Family	$6,000	$18,000	$8,000	$18,000	$12,200 Rx not included	$25,400 Rx not included
Lifetime Plan Maximum	Unlimted	Unlimted	Unlimited	Unlimited	Unlimited	Unlimited
InPatient Hospital Services						
Inpatient Hospitalization	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	90% after the deductible has been satisfied	70% 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%	100%	100%
Mental Health Benefits						
Inpatient Care	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	100% (subject to utilization review; waived for emergency admissions)	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency)
Outpatient Services	90% after the deductible has been satisfied	70%	90%	70%	$35 copay/visit with deductible waived for the first 3 visits	50%
Substance Abuse/Alcohol Abuse						
Inpatient Hospitalization	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	100% (subject to utilization review; waived for emergency admissions)	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency).
Inpatient Detoxification Services	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	90% after the deductible has been satisfied	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)	100% (subject to utilization review; waived for emergency admissions)	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency).
Outpatient Services	90% after the deductible has been satisfied	70%	90%	70%	$35 copay/visit with deductible waived for the first 3 visits	50%
Outpatient Detoxification Services	90% after the deductible has been satisfied	70%	90%	70%	$35 copay/visit with deductible waived for the first 3 visits	50%

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	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	In-Network Benefits	Out-of-Network Benefits
Prescription Drug Benefits						
Prescription Drug Deductible	$1,650/$3,300 medical/prescription/MH-SA in/out of network combined	$1,650/$3,300 medical/prescription/MH-SA in/out of network combined	$3,000/$6,000 medical/prescription/MH-SA in/out of network combined	$3,000/$6,000 medical/prescription/MH-SA in/out of network combined	N/A	N/A
Generic	$15 copay after deductible/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 copay after deductible/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)	$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 copay after deductible/Tier 1 Pharmacy; $40 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 copay after deductible/Tier 1 Pharmacy; $40 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)	$80 copay after deductble/Tier 1 Pharmacy; $80 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)	$80 copay after deductible/Tier 1 Pharmacy; $80 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)	$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
Mail Order						
Generic	$30 copay after deductible; provided by Express Scripts	Not covered	$30 copay after deductible; provided by Express Scripts	Not covered	$38 copay provided by Express Scripts	Not covered
Brand (Formulary/Preferred)	$80 copay after dedible; provided by Express Scripts	Not covered	$80 copay after deductible; 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	$150 copay provided by Express Scripts	Not covered
Number of Days Supply for Mail Order	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; 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	$35 copay/visit with deductible waived for the first 3 visits; limited to 24 visits per calendar year	50% limited to 24 visits/calendar year

The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.

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

Medical Premium*	**$2,308.56**	**$2,100.60**	**Single**	**Employee & Spouse**
Delta Dental PPO	**$111.79**	**$111.79**	**$466.84**	**$980.36**
Vision	**$30.35**	**$30.35**	**$111.79**	**$111.79**
Group Life	**$6.75**	**$6.75**	**$30.35**	**$30.35**
District Cap	**-$916.67**	**-$916.67**	**$6.75**	**$6.75**
Monthly Employee Cost	**$1,540.78**	**$1,332.82**	**-$916.67**	**-$916.67**
			$0.00	**$212.58**
			Employee & Child(ren)	**Family**
			$840.31	**$1,377.17**
			$111.79	**$111.79**
			$30.35	**$30.35**
			$6.75	**$6.75**
			-$916.67	**-$916.67**
			$72.53	**$609.39**