



**Perris Union High School District**

**Summary of Anthem HSA 1 Plan - Certificated/Mgmt/Confidential/Board/Cherter Schools**

Effective Date: July 1, 2018

**RENEWAL 2018**

<b>Effective Date</b>	07/01/2018	
<b>Renewal Date</b>	07/01/2019	
<b>Carrier Name</b>	<b>Anthem Blue Cross</b>	
<b>Plan Name</b>	HSA 1 - \$10/30 Rx	
<b>Eligible Class</b>	Eligible Employees	
	<b>In-Network Benefits</b>	<b>Out-of-Network Benefits</b>
<b>General Plan Information</b>		
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
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
Coinsurance	90%	70%
Office Visit/Exam	90%	70%
Outpatient Specialist Visit	90%	70%
Annual Out-of-Pocket Limit/Individual	\$3,000	\$9,000
Annual Out-of-Pocket Limit/Family	\$6,000	\$18,000
Lifetime Plan Maximum	Unlimited	Unlimited
<b>Inpatient Hospital Services</b>		
Inpatient Hospitalization	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%
<b>Emergency Services</b>		
Emergency Room	90%	90%
<b>Mental Helath Benefits</b>		
Inpatient Care	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required
Outpatient Care	90% prior MHN authorization required	70% prior MHN authorization required
<b>Prescription Drug Benefits</b>		
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	\$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)
Brand (Non-Formulary/Non-preferred)		
Number of Days Supply	30 days	30 days
<b>Mail Order</b>		
Mail Order Mandatory		
Generic	\$20 copay after deductible; provided by Express Scripts	Not covered
Brand (Formulary/Preferred)	\$60 copay after deductible; provided by Express Scripts	Not covered

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.



RENEWAL **2018**

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	<b>In-Network Benefits</b>	<b>Out-of-Network Benefits</b>
Brand (Non-Formulary/Non-preferred)		
Number of Days Supply for Mail Order	90 days	Not covered
<b>Other Services and Supplies</b>		
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