Keenan

Perris Union High School District

Anthem PPO 500 Blue Card vs. Anthem HSA 1600 Blue Card Plan Comparison

RENEWAL 2025

Carrier	Anthem Blue Cross		Anthem Blue Cross	
Plan Name	PPO 500 90/70 Blue Card · $15/50/15 Rx + Cost		HSA 1650 Blue Card · $10/30 Rx	
	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information				
Annual Deductible/Individual	$500	$1,000	$1,650 medical/prescription/MH-SA in/out of network combined	$1,650 medical/prescription/MH-SA in/out of network combined
Annual Deductible/Family	$1,500	$3,000	$3,300 medical/prescription/MH-SA in/out of network combined	$3,300 medical/prescription/MH-SA in/out of network combined
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 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
Deductible Included in Out-of-Pocket Limits	Yes	Yes	Yes	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimted	Unlimted
Outpatient Services				
Preventive Services				
Well-Child Care	100% deductible waived	70% limited to $20/exam	100% deductible waived	Not covered
Immunizations	100% deductible waived	70% limited to $12/immunization	100% deductible waived	Not covered
Well Woman Exams	100% deductible waived	70% deductible waived	100% deductible waived	Not covered
Mammograms	100% deductible waived	70% deductible waived	100% deductible waived	Not covered
Adult Periodic Exams with Preventive Tests	100% deductible waived	Not covered	100% deductible waived	Not covered
Diagnostic X-Ray and Lab Tests	80%	80%	80%	80%
Maternity Care				
Pregnancy and Maternity Care (Pre-Natal Care)	$30 copay/visit deductible waived	70%	90%	70%
Inpatient Hospital Services				
Inpatient Hospitalization	90%	70% plus $500 admission fee (waived for emergency admission)	90%	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)
Pre-Authorization of Services Required	Yes	Yes; $250 penalty/non-approval (waived for emergency admission)	Yes	Yes. If not pre-certified, penalty is $500 per admission (waived for emergency)
Semi-Private Room & Board; Including Services and Supplies	90%	70%	90%	70%
Surgical Services				
Outpatient Facility Charge	90%	70% limited to $350/admit	90%	70% limited to $350/admit
Emergency Services				
Emergency Room	90%	90%	90%	90%
Ambulance				
Air	90% non-medical emergency is subject to pre-service review	90% non-medical emergency is subject to pre-service review; limited to $50,000	90% non-medical emergency is subject to pre-service review	90% non-medical emergency is subject to pre-service review; limited to $50,000
Ground	90% non-medical emergency is subject to pre-service review	90% non-medical emergency is subject to pre-service review; limited to $50,000	90% non-medical emergency is subject to pre-service review	90% non-medical emergency is subject to pre-service review; limited to $50,000
Urgent Care				
Urgent Care Facility	$30 copay/visit deductible waived	70%	90%	70%
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.
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%

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Carrier	Anthem Blue Cross		Anthem Blue Cross	
Plan Name	PPO 500 90/70 Blue Card · $15/50/15 Rx + Cost		HSA 1650 Blue Card · $10/30 Rx	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drug Benefits				
Prescription Drug Deductible	N/A	N/A	$1,650 Indiv/$3,300 Family medical/prescription/MH-SA in/out of network combined	$1,650 Indiv/$3,300 Family medical/prescription/MH-SA in/out of network combined
Prescription Drug Annual Out-of-Pocket Limit/Individual	$1,000	$1,000	N/A	N/A
Prescription Drug Annual Out-of-Pocket Limit/Family	$3,000	$3,000	N/A	N/A
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)	$10 after deductible/ Tier 1 Pharmacy; $10 copay after ded+$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)	$30 after deductible/ Tier 1 Pharmacy; $30 copay after ded+$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)	N/A	N/A
Number of Days Supply	30 days	30 days	30 days	30 days
Mail Order				
Generic	$30 copay provided by Express Scripts	Not covered	$20 copay after deductible; provided by Express Scripts	Not covered
Brand (Formulary/Preferred)	$100 copay provided by Express Scripts	Not Covered	$60 copay after deductible; provided by Express Scripts	Not covered
Brand (Non-Formulary/Non-preferred)	$30 copay plus cost difference between and brand when generic equivalent is available; provided by Express Scripts	Not covered	N/A	N/A
Number of Days Supply for Mail Order	90 days	90 days	90 days	N/A
Other Services and Supplies				
Durable Medical Equipment & Prosthetic Devices	90%	70%	90%	70%
Home Health Care	90% Up to 100 (4hr) visits/calendar year; in/out-of-network combined	70% Up to 100 (4hr) visits/calendar year; in/out-of-network combined	80% limited to 100 visits/calendar year; one visit equals four hours or less; in/out-of-network combined	80% limited to 100 visits/calendar year; one visit equals four hours or less; in/out-of-network combined
Skilled Nursing or Extended Care Facility	90% Up to 100 days/calendar year; in/out-of-network combined	70% plus $500 admit fee after deductible is met; Up to 100 days/calendar year; in/out-of-network combined	80% limited to 100 days/calendar year; in/out-of-network combined	80% plus $500 admission fee after the deductible has been satisfied (waived for emergency) in/out-of-network combined
Hospice Care	100%	80%	100% deductible waived	80%
Chiropractic Services	90% Up 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
Acupuncture	90%	70%	90%	70%
Vision				
Copay				
Examination	100% deductible waived	70% limited to $20/exam	100% Screening included under preventive care	Not covered
Benefit Frequency				
Examination	12 months	12 months	12 months	Not covered
Hearing				
Screening	100% deductible waived	70% limited to $20/exam	100% Screening included under preventive care	Not covered
Aid(s)	90% limited to one hearing aid per ear every 3 years	70% limited to one hearing aid per ear every 3 years	90% limited to one hearing aid per ear every 3 years	70% limited to one hearing aid per ear every 3 years
Infertility				
Diagnosis	See plan certificate	See plan certificate	See plan certificate	See plan certificate
Treatment	See plan certificate	See plan certificate	See plan certificate	See plan certificate
Outpatient Rehabilitative Therapy Services				
Physical, Occupational and Speech Therapy	90% Up to to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined	70% limited to 24 visits/calendar year; 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; 24 visits/calendar year; phys/occ/chiro combined; in/out-of-network combined

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