Keenan

RENEWAL 2025

Mt. San Jacinto Community College

Summary of Anthem HMO 20, HMO 30 & DHMO 500 Select Plans

Carrier	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
Plan Name	HMO 20 - $5/25/40 Rx	HMO 30 - $10/30/60 Rx	DHMO 500 Select - $10/30/60 Rx
Benefit Summary	Eligible Employees	Eligible Employees	Eligible Employees
General Plan Information			
Annual Deductible/Individual	$0	$0	$500
Annual Deductible/Family	$0	$0	$1,000
Coinsurance	100%	100%	100%
Office Visit/Exam	$20 copay	$30 copay	$40 copay
Outpatient Specialist Visit	$20 copay	$30 copay	$40 copay
Annual Out-of-Pocket Limit/Individual	$500 Rx not included	$500 Rx not included	$1,500 Rx not included
Annual Out-of-Pocket Limit/Family	$1,500 Rx not included	$1,500 Rx not included	$4,500 Rx not included
Deductible Included in Out-of-Pocket Limits	N/A	N/A	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes	Yes
Outpatient Services			
Preventive Services			
Well-Child Care	100%	100%	100%
Immunizations	100%	100%	100%
Well Woman Exams	100%	100%	100%
Mammograms	100%	100%	100%
Adult Periodic Exams with Preventive Tests	100%	100%	100%
Diagnostic X-Ray and Lab Tests	100% $20 copay for CT/SPECT/PET/MRA/MRI	100% $30 copay for CT/SPECT/PET/MRA/MRI	100% $40 copay for CT/SPECT/PET/MRA/MRI
Maternity Care			
Pregnancy and Maternity Care (Pre-Natal Care)	$20 copay	$30 copay	$40 copay
Inpatient Hospital Services			
Inpatient Hospitalization	100%	100%	$250 admit fee after deductible is met
Pre-Authorization of Services Required	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	100%	100%
Surgical Services			
Outpatient Facility Charge	100%	100%	100% after $250 copay per admit after deductible has been met
Emergency Services			
Emergency Room	$100 copay waived if admitted	$100 copay waived if admitted	$100 copay waived if admitted
Ambulance			
Air	100%	100%	100%
Ground	100%	100%	100%
Urgent Care			
Urgent Care Facility	$20 copay	$30 copay	$40 copay

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Benefit Summary	Eligible Employees	Eligible Employees	Eligible Employees
Mental Health Benefits			
Inpatient Care	100% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)
Outpatient Care	100% (Behavioral Health treatment for autism or pervasive development disorders require pre-service review.)	100% (Behavioral Health treatment for autism or pervasive development disorders require pre-service review.)	100% (Behavioral Health treatment for autism or pervasive development disorders require pre-service review.)
Substance Abuse			
Inpatient Care			
Inpatient Hospitalization	100% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)
Inpatient Detoxification Services	100% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)
Outpatient Care			
Outpatient Services	100%	100%	100%
Prescription Drug Benefits			
Prescription Drug Deductible	N/A	N/A	N/A
Prescription Drug Annual Out-of-Pocket Limit/Individual	$1,000	$1,000	$1,000
Prescription Drug Annual Out-of-Pocket Limit/Family	$3,000	$3,000	$3,000
Generic	$5 copay/Tier 1 Pharmacy; $5 copay + $15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	$10 copay/Tier 1 Pharmacy $10 copay + $15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	$10 copay/Tier 1 Pharmacy 10 copay +$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)
Brand (Formulary/Preferred)	$25 copay/Tier 1 Pharmacy $25 copay +$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	$30 copay/Tier 1 Pharmacy $30 copay +$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	$30 copay/Tier 1 Pharmacy $30 copay +$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)
Brand (Non-Formulary/Non-preferred)	$40 copay/Tier 1 Pharmacy $40 copay +$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	$60 copay/Tier 1 Pharmacy $60 copay +$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	$60 copay/Tier 1 Pharmacy $60 copay +$15/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
Mail Order			
Generic	$10 copay provided by Express Scripts	$20 copay provided by Express Scripts	$20 copay provided by Express Scripts
Brand (Formulary/Preferred)	$50 copay provided by Express Scripts	$60 copay provided by Express Scripts	$60 copay provided by Express Scripts
Brand (Non-Formulary/Non-preferred)	$80 copay provided by Express Scripts	$120 copay provided by Express Scripts	$120 copay provided by Express Scripts
Number of Days Supply for Mail Order	90 days	90 days	90 days

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Benefit Summary	Eligible Employees	Eligible Employees	Eligible Employees
Other Services and Supplies			
Durable Medical Equipment & Prosthetic Devices	100%	100%	100%
Home Health Care	100% limited to 100 visits/calendar year; one visit equals four hours or less	100% limited to 100 visits/calendar year; one visit equals four hours or less	100% limited to 100 visits/calendar year; one visit equals four hours or less
Skilled Nursing or Extended Care Facility	100% limited to 100 days/calendar year	100% limited to 100 days/calendar year	100% limited to 100 days/calendar year
Hospice Care	100%	100%	100%
Chiropractic Services	Not covered	Not covered	Not covered
Acupuncture	$20 copay; when approved by your medical group	$30 copay when approved by your medical group	$40 copay when approved by your medical group
Vision			
Examination	100%	100%	100%
Benefit Frequency			
Examination	Once every 12 months	Once every 12 months	Once every 12 months
Hearing			
Screening	100%	100%	100%
Aid(s)	100% limited to one hearing aid per ear every 3 years	100% limited to one hearing aid per ear every 3 years	100% limited to one hearing aid per ear every 3 years
Infertility			
Diagnosis	See plan certificate	See plan certificate	See plan certificate
Treatment	See plan certificate	See plan certificate	See plan certificate
Outpatient Rehabilitative Therapy Services			
Physical	100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined	100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined	100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined
Occupational	100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined	100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined	100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined
Speech	100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined	100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined	100% limited to a 60-day period of care after illness or injury. Phys./occ/chiro/speech combined