

Mt. San Jacinto Community College

RENEWAL 2024

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

Anthern Blue Cross				
Benefit Summary	Carrier	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
Eligible Employees	Plan Name	HMO 20 - \$5/25/40 Rx	HMO 30 - \$10/30/60 Rx	DHMO 500 Select - \$10/30/60 Rx
Senset Plan Information	Benefit Summary			Eligible Employees
Annual Deductible/Family		5 7		
100% 100%	·	\$0	\$0	\$500
S20 copay \$30 copay \$40	Annual Deductible/Family	\$0	\$0	\$1.000
Qubatient Specialist Visit	Coinsurance	100%	100%	100%
Annual Out-of-Pocket Limit/Individual \$500 Rx not included \$1,500	Office Visit/Exam	\$20 copay	\$30 copay	\$40 copay
Annual Out-of-Pocket Limit/ Family Annual Out-of-Pocket Limit/ Family Deductible Included in Out-of-Pocket Limits Lifetime Plan Maximum Unlimited Ves Yes Yes Yes Outpatient Services Well-Child Care 100% 100% 100% 100% 100% 100% 100% 10	Outpatient Specialist Visit	\$20 copay	\$30 copay	\$40 copay
Deductible Included in Out-of-Pocket Limits	Annual Out-of-Pocket Limit/Individual	\$500 Rx not included	\$500 Rx not included	\$1,500 Rx not included
Unlimited Unlimited Unlimited Unlimited Unlimited Primary Care Physician Election Required Yes	Annual Out-of-Pocket Limit/Family	\$1,500 Rx not included	\$1,500 Rx not included	\$4,500 Rx not included
Primary Care Physician Election Required Yes Yes Yes Yes	Deductible Included in Out-of-Pocket Limits	N/A	N/A	Yes
Outpatient Services Preventive Services Well-Child Care 100% 100% 100% Immunizations 100% 100% 100% 100% Well Woman Exams 100% 100% 100% 100% Mammograms 100% 100% 100% 100% Adult Periodic Exams with Preventive Tests 100% 100% 100% 100% Diagnostic X-Ray and Lab Tests 100% \$20 copay for 100% \$30 copay for CT/SPECT/PET/MRA/MRI <		Unlimited	Unlimited	Unlimited
Preventive Services	Primary Care Physician Election Required	Yes	Yes	Yes
Well-Child Care	Outpatient Services			
Immunizations 100%	Preventive Services			
Well Woman Exams	Well-Child Care	100%	100%	100%
Mammograms Adult Periodic Exams with Preventive Tests 100% 100% 100% 100% 100% 100% 100% 100	Immunizations	100%	100%	100%
Adult Periodic Exams with Preventive Tests 100% \$100% \$20 copay for CT/SPECT/PET/MRA/MRI 100% \$30 copay for CT/SPECT/PET/MRA/MRI CT/SPECT/PET/MRA/MRI 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%	Well Woman Exams		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 Maternity Care Pregnancy and Maternity Care (Pre-Natal Care) Inpatient Hospital Services Inpatient Hospitalization Inpatient Hospitalization Pre-Authorization of Services Required Semi-Private Room & Board; Including Services and Supplies Surgical Services Outpatient Facility Charge 100% 100% 100% 100% 100% 100% 100% 10				
Maternity Care Pregnancy and Maternity Care (Pre-Natal Care) Pregnancy and Maternity Care (Pre-Natal Care) Inpatient Hospital Services Required Inpatient Hospital Services Inpatient Hospital Services Required Inpatient Facility Charge Inpatient Hospital Services Inpat				
Maternity Care Pregnancy and Maternity Care (Pre-Natal Care) Pregnancy and Maternity Care (Pre-Natal Care) Inpatient Hospital Services Inpatient Hospitalization Pre-Authorization of Services Required Semi-Private Room & Board; Including Services and Supplies Surgical Services Outpatient Facility Charge Outpatient Facility Charge Emergency Services Emergency Room Air Air Air Air 100% 100% 100% 100% 100% 100% 100% 100	Diagnostic X-Ray and Lab Tests			
Pregnancy and Maternity Care (Pre-Natal Care) Inpatient Hospital Services Inpatient Hospitalization Pre-Authorization of Services Required Semi-Private Room & Board; Including Services and Supplies Surgical Services Outpatient Facility Charge Emergency Services Emergency Room Air Air Ground Urgent Care \$20 copay \$30 copay \$30 copay \$40 copay		CT/SPECT/PET/MRA/MRI	CT/SPECT/PET/MRA/MRI	CT/SPECT/PET/MRA/MRI
Inpatient Hospital Services Inpatient Hospitalization 100% 100% \$250 admit fee after deductible is met Pre-Authorization of Services Required Yes Yes Yes Yes Semi-Private Room & Board; Including Services and Supplies 100% 100% 100% 100% Surgical Services Outpatient Facility Charge 100% 100% after \$250 copay per admit after deductible has been met				
Inpatient Hospitalization Pre-Authorization of Services Required Pre-Authorization of Services Required Semi-Private Room & Board; Including Services and Supplies Surgical Services Outpatient Facility Charge Emergency Services Emergency Room Ambulance Air Ground Urgent Care		\$20 copay	\$30 copay	\$40 copay
Pre-Authorization of Services Required Semi-Private Room & Board; Including Services and Supplies 100% 100% Surgical Services Outpatient Facility Charge 100% 100% 100% 100% after \$250 copay per admit after deductible has been met Emergency Services Emergency Room Emergency Room 100% 100% 100% 100% 100% 100% 100% 100				
Semi-Private Room & Board; Including Services and Supplies Surgical Services Outpatient Facility Charge Outpatient Facility Charge 100% 100% 100% 100% after \$250 copay per admit after deductible has been met Emergency Services Emergency Room Ambulance Air Air 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100%		/0	/0	*
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 Ambulance Air 100% Ground 100% 100% 100% 100% 100% 100% 100%				
Outpatient Facility Charge 100% 100% after \$250 copay per admit after deductible has been met Emergency Services Emergency Room \$100 copay waived if admitted Ambulance Air Air 100% Ground 100% 100% 100% 100% 100% 100% 100% 100		100%	100%	100%
Emergency Services\$100 copay waived if admitted\$100 copay waived if admittedEmergency Room\$100 copay waived if admitted\$100 copay waived if admittedAmbulanceAir100%100%Ground100%100%100%Urgent Care100%100%100%				
Emergency Services Emergency Room \$100 copay waived if admitted \$100 copay waived if admitted \$100 copay waived if admitted Ambulance Air \$100% \$10	Outpatient Facility Charge	100%	100%	
Emergency Room \$100 copay waived if admitted \$100 copay waived if admitted \$100 copay waived if admitted Ambulance Air \$100%				deductible has been met
Emergency Room \$100 copay waived if admitted \$100 copay waived if admitted \$100 copay waived if admitted Ambulance Air \$100%	Emergency Services			
Ambulance Air 100% 100% Ground 100% 100% Urgent Care 100% 100%		\$100 copay waived if admitted	\$100 copay waived if admitted	\$100 copay waived if admitted
Air 100% 100% Ground 100% 100% Urgent Care 100% 100%		,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,
Ground 100% 100% 100% Urgent Care		100%	100%	100%
Urgent Care				
				13370
		\$20 copay	\$30 copay	\$40 copay



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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
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 +	\$10 copay/Tier 1 Pharmacy \$10 copay +	\$10 copay/Tier 1 Pharmacy 10 copay
		\$15/Tier 2 Pharmacy provided by ESI (see	+\$15/Tier 2 Pharmacy provided by ESI
	www.express-scripts.com for a list of pharmacies)	www.express-scripts.com for a list of pharmacies)	(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	\$30 copay/Tier 1 Pharmacy \$30 copay +\$15/Tier 2 Pharmacy provided by ESI	\$30 copay/Tier 1 Pharmacy \$30 copay +\$15/Tier 2 Pharmacy provided by ESI
	(see www.express-scripts.com for a list of pharmacies)	(see www.express-scripts.com for a list of pharmacies)	(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	\$60 copay/Tier 1 Pharmacy \$60 copay +\$15/Tier 2 Pharmacy provided by ESI	\$60 copay/Tier 1 Pharmacy \$60 copay +\$15/Tier 2 Pharmacy provided by ESI
	(see www.express-scripts.com for a list of pharmacies)	(see www.express-scripts.com for a list of pharmacies)	(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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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
Other Services and Supplies			
Durable Medical Equipment & Prosthetic Devices	100%	100%	100%
Home Health Care			
	100% limited to 100 visits/calendar year;	100% limited to 100 visits/calendar year;	100% limited to 100 visits/calendar year;
	one visit equals four hours or less	one visit equals four hours or less	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	\$30 copay when approved by your medical	\$40 copay when approved by your medical
	group	group	group
Vision	8. oak	8.000	8: • «h
Examination	100%	100%	100%
Benefit Frequency	/,	7,0	70
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	100% limited to one hearing aid per ear	100% limited to one hearing aid per ear
	every 3 years	every 3 years	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	1000 limited to a 60 day paried of care	1000 limited to a 60 day paried of care	1000 limited to a 60 day paried of save
	100% limited to a 60-day period of care after illness or injury.	100% limited to a 60-day period of care after illness or injury.	100% limited to a 60-day period of care after illness or injury.
	Phys./occ/chiro/speech combined	Phys./occ/chiro/speech combined	Phys./occ/chiro/speech combined
Occupational	r nys./ occ/chiro/ speech combined	1 Hys.7 occ7 chill o7 speech combined	r riys./ occ/ criii o/ speecir combined
Occupational	100% limited to a 60-day period of care	100% limited to a 60-day period of care	100% limited to a 60-day period of care
	after illness or injury.	after illness or injury.	after illness or injury.
	Phys./occ/chiro/speech combined	Phys./occ/chiro/speech combined	Phys./occ/chiro/speech combined
Speech			
	100% limited to a 60-day period of care	100% limited to a 60-day period of care	100% limited to a 60-day period of care
	after illness or injury.	after illness or injury.	after illness or injury.
	Phys./occ/chiro/speech combined	Phys./occ/chiro/speech combined	Phys./occ/chiro/speech combined