



Mt. San Jacinto Community College

Summary of Anthem HSA 1600 Plan - All Employees

RENEWAL **2025**

Effective Date

7/1/2025

Carrier

Anthem Blue Cross

Plan Name

HSA 1650 - \$10/30 Rx

Benefit Summary

Eligible Employees

	In-Network	Out-of-Network
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
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
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
Inpatient Hospital Services		
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% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)
Emergency Services		
Emergency Room	90%	90%
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.
Outpatient Care	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.
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.
Outpatient Care		
Outpatient Services	90%	70%

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.

Effective Date	7/1/2025	
Carrier	Anthem Blue Cross	
Plan Name	HSA 1650 - \$10/30 Rx	
Benefit Summary	Eligible Employees	
	In-Network	Out-of-Network
Prescription Drug Benefits		
Prescription Drug Deductible	\$1,650 ind/\$3300 fam medical/prescription/MH-SA in/out of network combined	\$1,650 ind/\$3300 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)
Number of Days Supply	30 days	30 days
Mail Order		
Generic	\$20 copay after deductible; provided by Express Scripts	Not covered
Brand (Formulary/Preferred)	\$60 copay after deductible; provided by Express Scripts	Not covered
Number of Days Supply for Mail Order	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