

## Mt. San Jacinto Community College

Summary of Anthem PPO 500, PPO 750, PPO Essentials & PPO MVP Plans - All Employees



Carrier	Anthem Blue Cross PPO 500 90/70 · \$10/30/10 Rx + Cost Eligible Employees		Anthem Blue Cross PPO 750 · \$15/50/15 Rx + Cost Eligible Employees		Anthem Blue Cross PPO Essentials - \$15/50/15 Rx + Cost Eligible Employees		Anthem Blue Cross PPO MVP Eligible Employees	
Plan Name								
Benefit Summary								
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information								
Annual Deductible/Individual	\$500	\$1,000	\$750	\$1,500	\$1,250	\$1,250	\$5,900	\$11,800
Annual Deductible/Family	\$1,500	\$3,000	\$2,250	\$4,500	\$3,750	\$3,750	\$11,800	\$23,600
Coinsurance	90%	70%	80%	60%	70%	50%	100% after the deductible has been satisfied	50%
Office Visit/Exam	\$30/Visit; deductible waived	70%	\$40/Visit; deductible waived	60%	\$40 copay; deductible waived	50%	\$35 copay; deductible waived first 3 visits/combined services	50%
Outpatient Specialist Visit	\$30/Visit; deductible waived	70%	\$40/Visit; deductible waived	60%	\$40 copay; deductible waived	50%	\$35 copay; deductible waived first 3 visits/combined services	50%
Annual Out-of-Pocket Limit/Individual	\$3,000 Rx not included	\$6,000 Rx not included	\$3,000 Rx not included	\$6,000 Rx not included	\$3,000 Rx not included	\$6,000 Rx not included	\$6,100 Rx not included	\$12,700 Rx not included
Annual Out-of-Pocket Limit/Family	\$9,000 Rx not included	\$18,000 Rx not included	\$9,000 Rx not included	\$18,000 Rx not included	\$9,000 Rx not included	\$18,000 Rx not included	\$12,200 Rx not included	\$25,400 Rx not included
Lifetime Plan Maximum	Unlimited	Unlimted	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
npatient Hospital Services								
Inpatient Hospitalization	90%	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	80%	60% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	70%	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	100% after the deductible has been satisfied	50% plus \$500 admissio fee after the deductible has been satisfied (waive for emergency)
Semi-Private Room & Board; Including Services and Supplies	90%	70%	80%	60%	70%	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	100% after the deductible has been satisfied	50% plus \$500 admission fee after the deductible has been satisfied (waive for emergency)
Emergency Services								
Emergency Room	90%	90%	80%	80%	70%	70%	100%	100%



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Carrier	Anthem Blue Cross		Anthem Blue Cross		Anthem Blue Cross		Anthem Blue Cross	
Plan Name	PPO 500 90/70 · \$10/30/10 Rx + Cost Eligible Employees		PPO 750 - \$15/50/15 Rx + Cost Eligible Employees		PPO Essentials · \$15/50/15 Rx + Cost  Eligible Employees		PPO MVP Eligible Employees	
Benefit Summary								
					5 , ,			
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
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	utilization review; waived for emergency	70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained.	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)
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.	\$40 copay; deductible waived (Behavioral Health treatment for Autism or Pervasive Development disorders require pre- service review)	50%	\$35 copay/visit with deductible waived for the first 3 visits (Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)	50%
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.	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)
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	utilization review; waived for emergency	70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained.	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)
Outpatient Care								
Outpatient Services	90%	70%	90%	70%	\$40 copay; deductible waived	50%	\$35 copay/visit with deductible waived for the first 3 visits	50%



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Plan Name								
Benefit Summary								
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Benefits								
Generic	\$10 copay/Tier 1	50% + an additional \$15	\$15 copay/Tier 1	50% + an additional \$15	\$15 copay/Tier	50% + an additional \$15	\$19 copay/Tier 1	50% + an additional \$1
	Pharmacy \$10 copay	fee applies per	Pharmacy; \$15 copay +	fee applies per	Pharmacy; \$15 copay +	fee applies per	Pharmacy; \$19 copay +	fee applies per
	+\$15/Tier 2 Pharmacy	prescription for a Tier 2	\$15/Tier 2 Pharmacy	prescription for a Tier 2	\$15/Tier 2 Pharmacy	prescription for a Tier 2	\$15/Tier 2 Pharmacy	prescription for a Tier 2
	provided by ESI (see	Pharmacy; provided by	provided by ESI (see	Pharmacy; provided by	provided by ESI (see	Pharmacy; provided by	provided by ESI (see	Pharmacy; provided by
	www.express-scripts.com	ESI (see www.express-	www.express-scripts.com	ESI (see www.express-	www.express-scripts.com	ESI (see www.express-	www.express-scripts.com	ESI (see www.express-
	for a list of pharmacies)	scripts.com for a list of	for a list of pharmacies)	scripts.com for a list of	for a list of pharmacies)	scripts.com for a list of	for a list of pharmacies)	scripts.com for a list o
		pharmacies)		pharmacies)		pharmacies)		pharmacies)
Brand (Formulary/Preferred)	\$30 copay/Tier 1	50% + an additional \$15	\$50 copay/Tier 1	50% + an additional \$15	\$50 copay/Tier 1	50% + an additional \$15	\$50 copay/Tier 1	50% + an additional \$1
	Pharmacy \$30 copay	fee applies per	Pharmcy; \$50 copay +	fee applies per	Pharmacy; \$50 copay +	fee applies per	Pharmacy; \$50 copay +	fee applies per
	+\$15/Tier 2 Pharmacy	prescription for a Tier 2	\$15/Tier 2 Pharmacy	prescription for a Tier 2	\$15/Tier 2 Pharmacy	prescription for a Tier 2	\$15/Tier 2 Pharmacy	prescription for a Tier 2
	provided by ESI (see	Pharmacy; provided by	provided by ESI (see	Pharmacy; provided by	provided by ESI (see	Pharmacy; provided by	provided by ESI (see	Pharmacy; provided by
	www.express-scripts.com	ESI (see www.express-	www.express-scripts.com	ESI (see www.express-	www.express-scripts.com	ESI (see www.express-	www.express-scripts.com	ESI (see www.express-
	for a list of pharmacies)	scripts.com for a list of	for a list of pharmacies)	scripts.com for a list of	for a list of pharmacies)	scripts.com for a list of	for a list of pharmacies)	scripts.com for a list o
		pharmacies)		pharmacies)		pharmacies)		pharmacies)
Brand (Non-Formulary/Non-preferred)	\$10 copay/Tier 1	50% + an additional \$15	\$15 copay/Tier 1	50% + an additional \$15	\$15 copay/Tier 1	50% + an additional \$15	\$75 copay/Tier 1	50% + an additional \$1
	Pharmacy \$10 copay	fee applies per	Pharmacy; \$15 copay +	fee applies per	Pharmacy; \$15 copay +	fee applies per	Pharmacy; \$75 copay +	fee applies per
	+\$15/Tier 2 Pharmacy +	prescription for a Tier 2	\$15/Tier 2 Pharmacy +	prescription for a Tier 2	\$15/Tier 2 Pharmacy +	prescription for a Tier 2	\$15/Tier 2 Pharmacy	prescription for a Tier
	cost difference between	Pharmacy + cost	cost difference between	Pharmacy + cost	cost difference between	Pharmacy + cost	provided by ESI (see	Pharmacy; provided by
		difference between generic		difference between generic		difference between generic		ESI (see www.express-
	generic equivalent is	and brand when generic	generic equivalent is	and brand when generic	generic equivalent is	and brand when generic	for a list of pharmacies)	scripts.com for a list o
	available; (see	equivalent is available;	available; (see	equivalent is available;	available; (see	equivalent is available; (see www.express-		pharmacies)
	www.express-scripts.com for a list of pharmacies)	(see www.express- scripts.com for a list of	www.express-scripts.com for a list of pharmacies)	(see www.express- scripts.com for a list of	www.express-scripts.com for a list of pharmacies)	scripts.com for a list of		
Number of Days Supply	30 days	30 days	30 davs	30 days	30 days	30 days	30 days	30 days
, ,,,	30 days	30 days	30 days	30 days	30 days	30 days	30 days	30 days
Mail Order								
Generic	\$20 copay provided by Express Scripts	Not covered	\$30 copay provided by Express Scripts	Not covered	\$30 copay provided by Express Scripts	Not covered	\$38 copay provided by Express Scripts	Not covered
	Express Scripts		Express Scripts		Express Scripts		Express Scripts	
Brand (Formulary/Preferred)	\$60 copay provided by	Not covered	\$100 copay provided by	Not covered	\$100 copay provided by	Not covered	\$100 copay provided by	Not covered
	Express Scripts		Express Scripts		Express Scripts		Express Scripts	
Brand (Non-Formulary/Non-	\$20 copay plus cost	Not covered	\$30 copay plus cost	Not covered	\$30 copay plus cost	Not covered	\$150 copay provided by	Not covered
preferred)	difference between generic		difference between generic		difference between generic	1101 0010104	Express Scripts	1101 0010104
protetroay	and brand when generic		and brand when generic		and brand when generic			
	equivalent is available;		equivalent is available;		equivalent is available;			
	provided by Express		provided by Express		provided by Express			
	Scripts		Scripts		Scripts			
Number of Days Supply for Mail	90 days	Not covered	90 days	N/A	90 days	N/A	90 days	N/A
Order	50 44,5		20 44,0		20 44,0		50 44,0	
Other Services and Supplies								
Chiropractic Services	90% limited to 24	70% chiro/phys/occ	80% limited to 24	60% limited to 24	70% limited to 24	50% limited to 24	Not covered	Not covered
	visits/calendar year;	therapy combined; in/out		visits/calendar year;	visits/calendar year;	visits/calendar year;	1101 0010104	1101 0010104
	chiro/phys/occ therapy	of network combined	chiro/phys/occ therapy	chiro/phys/occ therapy	chiro/phys/occ therapy	chiro/phys/occ therapy		
	combined; in/out of		combined; in/out of	combined; in/out of	combined; in/out of	combined; in/out of		
	network combined		network combined	network combined	network combined	network combined		
	mothern combined		mothern combined	mothern combined	mothern combined	mothern combined		

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