Keenan

Mt. San Jacinto Community College

Summary of Kaiser HMO 20, DHMO 500, HMO MVP & DHMO HSA Plans - All Employees

RENEWAL 2025

Effective Date	07/01/2025	07/01/2025	07/01/2025	07/01/2025
Renewal Date	07/01/2026	07/01/2026	07/01/2026	07/01/2026
Carrier	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**
Plan Name	HMO 20	DHMO 500	HMO MVP	DHMO HSA
	Eligible Employees	Eligible Employees	Eligible Employees	Eligible Employees
General Plan Information				
Annual Deductible/Individual	$0	$500	$4,500	$1,650 medical/prescription combined
Annual Deductible/Family	$0	$1,000	$9,000	$3,300 medical/prescription combined
Coinsurance	100%	80%	60%	90%
Office Visit/Exam	$20 copay	$20 copay	$50 copay; after deductible	90% after deductible
Outpatient Specialist Visit	$20 copay	$20 copay	$50 copay; after deductible	90% after deductible
Annual Out-of-Pocket Limit/Individual	$1,500	$3,000	$6,000	$3,200
Annual Out-of-Pocket Limit/Family	$3,000	$6,000	$12,000	$6,400
Deductible Included in Out-of-Pocket Limits	N/A	Yes	Yes (except prescription drugs)	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	No	No	No	No
Outpatient Services				
Preventive Services				
Well-Child Care	100% through age 23 months	100% deductible waived through age 23 months	100% deductible waived through age 23 months	100% through age 23 months; deductible waived
Immunizations	100%	100% deductible waived	100% deductible waived	100% deductible waived
Well Woman Exams	100%	100% deductible waived	100% deductible waived	100% deductible waived
Mammograms	100%	100% for preventive, deductible waived	100% for preventive, deductible waived	100% for preventive; deductible waived for preventive
Adult Periodic Exams with Preventive Tests	100%	100% deductible waived	100% deductible waived	100% deductible waived
Diagnostic X-Ray and Lab Tests	100% $20 copay for MRI/CT/PET	$10 copay per encounter after deductible; $50 copay per procedure for MRI/CT/PET after deductible	100% deductible waived; MRI, CT & PET scans 60% up to a maximum of $150 per procedure	100% preventive X-rays deductible waived; other than preventive 90% after deductible
Maternity Care				
Pregnancy and Maternity Care (Pre-Natal Care)	100%	100%	100%	100%
Inpatient Hospital Services				
Inpatient Hospitalization	100%	80% after deductible	60% after deductible	90% after deductible
Pre-Authorization of Services Required	Yes	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	80% after deductible	60% after deductible	90% after deductible
Surgical Services				
Outpatient Facility Charge	$20 copay per procedure	80% after deductible	60% after deductible	90% after deductible

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Plan Name	HMO 20	DHMO 500	HMO MVP	DHMO HSA
	Eligible Employees	Eligible Employees	Eligible Employees	Eligible Employees
Emergency Services				
Emergency Room	$100 copay waived if admitted	80% after deductible	$250 copay; after deductible	90% after deductible
Ambulance				
Air	100%	$150 copay per trip; after deductible	60% after deductible	90% after deductible
Ground	100%	$150 copay per trip; after deductible	60% after deductible	90% after deductible
Urgent Care				
Urgent Care Facility	$20 copay	$20 copay; deductible waived	$50 copay; after deductible	90% after deductible
Mental Health Benefits				
Inpatient Care	100%	80% after deductible	60% after deductible	90% after deductible
Outpatient Care	$20 copay	$20 copay; deductible waived	$50 copay; after deductible	90% after deductible
Substance Abuse				
Inpatient Care				
Inpatient Hospitalization	100%	80% after deductible	60% after deductible	90% after deductible
Inpatient Detoxification Services	100%	80% after deductible	60% after deductible	90% after deductible
Outpatient Care				
Outpatient Services	$20 copay	$20 copay; deductible waived	$50 copay; after deductible	90% after deductible
Prescription Drug Benefits				
Prescription Drug Deductible		$100 per member/calendar year	$250	$1,650 ind/$3,300 fam; medical/prescription combined
Prescription Drug Annual Out-of-Pocket Limit/Individual				$1,000
Prescription Drug Annual Out-of-Pocket Limit/Family				$2,000
Generic	$10 copay	$10 copay; deductible waived	$15 copay; deductible waived	$10 copay; after deductible
Brand (Formulary/Preferred)	$20 copay	$30 copay; after $100 prescription deductible	$35 copay; after prescription deductible	$30 copay; after deductible
Number of Days Supply	30 days	30 days	30 days	30 days
Mail Order				
Generic	$20 copay	$20 copay; deductible waived	$30 copay; deductible waived	$20 copay; after deductible
Brand (Formulary/Preferred)	$40 copay	$60 copay; after $100 prescription deductible	$70 copay; after prescription deductible	$60 copay; after deductible
Number of Days Supply for Mail Order	100 days	100 days	100 days	100 days

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Plan Name	HMO 20	DHMO 500	HMO MVP	DHMO HSA
	Eligible Employees	Eligible Employees	Eligible Employees	Eligible Employees
Other Services and Supplies				
Durable Medical Equipment & Prosthetic Devices	100%	80% deductible waived	60% deductible waived	90% after deductible; limited to $2,500 calendar year benefit
Home Health Care	100% limited to 100 visits/calendar year	100% limited to 100 visits/calendar year; deductible waived	100% deductible waived; limited to 100 visits/calendar year	100% after deductible; limited to 100 visits/calendar year
Skilled Nursing or Extended Care Facility	100% limited to 100 days/benefit period	80% after deductible; limited to 100 days/benefit period	60% after deductible; limited to 100 days/benefit period	90% after deductible; limited to 100 days/benefit period
Hospice Care	100%	100% deductible waived	100% deductible waived	100% after deductible
Chiropractic Services	Not covered	Not covered	Not covered	Not covered
Acupuncture	Not covered	Not covered	Not covered	Not covered
Vision				
Copay				
Examination	100%	100%	100%	100%
Benefit Frequency				
Examination	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Hearing				
Screening	100%	100%	100%	100%
Aid(s)	Not covered	Not covered	Not covered	Not covered
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	$20 copay	$20 copay; after deductible	$50 copay; after deductible	90% after deductible
Occupational	$20 copay	$20 copay; after deductible	$50 copay; after deductible	90% after deductible
Speech	$20 copay	$20 copay; after deductible	$50 copay; after deductible	90% after deductible