

Plan Type (PPO or HMO)

Carrier (Anthem Blue Cross, Blue Shield, or Kaiser)

PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Anthem	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem

District Name ALLAN HANCOCK COLLEGE

Bargaining Unit MANAGEMENT, SUPERVISORY, CONFIDENTIAL, CLASSIFIED AND FACULTY



2021-2022	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem
	100-A \$10	90-C \$20	90-G \$20	80-E \$20	80-G \$30	HSA-A Individual	HSA-A Family
MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	\$0/\$0	\$200/\$500	\$500/\$1,000	\$300/\$600	\$500/\$1,000	1500*	\$2,800/\$3,000*
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	\$1,000/\$3,000	\$1,000/\$3,000	\$1,000/\$3,000	\$1,000/\$3,000	\$2,000/\$4,000	3000*	\$3,000/\$6,000*

*Includes Rx

*Includes Rx

PROFESSIONAL SERVICES

Office Visit (OV) co-pay (\$0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	\$10	\$20	\$20	\$20	\$30	Deductible, then 10%	Deductible, then 10%
Urgent Care co-pay	\$10	\$20	\$20	\$20	\$30	10%	10%
Specialists/Consultants co-pay	\$10	\$20	\$20	\$20	\$30	10%	10%
Prenatal, postnatal office visit co-pay	\$10	\$20	\$20	\$20	\$30	10%	10%
Scans: CT, CAT, MRI, PET etc.	0%	10%	10%	20%	20%	10%	10%
Diagnostic X-ray & Laboratory Procedures	0%	10%	10%	20%	20%	10%	10%
Infertility (diagnosis/treatment of causes of infertility subject to plan benefits)	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived

HOSPITAL & SKILLED NURSING FACILITY SERVICES

Emergency Room visit (waived if admitted)	0% \$100 co-pay	10% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	20% \$100 co-pay	10% \$100 co-pay	10% \$100 co-pay
Inpatient Hospital (preauthorization required) - limits may apply	0%	10%	10%	20%	20%	10%	10%
Outpatient Hospital	0%	10%	10%	20%	20%	10%	10%
Surgery, Outpatient (performed in Surgery Center)	0%	10%	10%	20%	20%	10%	10%
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	10%	10%	20%	20%	10%	10%

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

INPATIENT: Facility Based Care (preauth required)	0%	10%	10%	20%	20%	10%	10%
OUTPATIENT: Facility Based Care (preauth required)	0%	10%	10%	20%	20%	10%	10%

OTHER SERVICES

Acupuncture - Limits apply	0%	10%	10%	20%	20%	10%	10%
Ambulance (Ground or Air)	0% \$100 co-pay	10% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	20% \$100 co-pay	10% \$100 co-pay	10% \$100 co-pay

Chiropractic - Limits apply	0%	10%	10%	20%	20%	10%	10%
Durable Medical Equipment (DME)	0%	10%	10%	20%	20%	10%	10%
Physical and Occupational Therapy - Limits apply	0%	10%	10%	20%	20%	10%	10%
Hearing Aids	Amount in excess of \$700 allowance/24 months	10% and Amount in excess of \$700 allowance/24 months	10% and Amount in excess of \$700 allowance/24 months	20% and Amount in excess of \$700 allowance/24 months	20% and Amount in excess of \$700 allowance/24 months	10% and Amount in excess of \$700 allowance/24 months	10% and Amount in excess of \$700 allowance/24 months

PHARMACY BENEFITS

Plan	9-35	9-35	7-25	9-35	7-25	HSA-A Rx Individual	HSA-A Rx Family
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none	none	Included w/ Medical ded	Included w/ Medical ded
Individual/Family Rx Out-of-Pocket (OOP) Max <i>(includes Rx deductibles and co-pays)</i>	\$2,500/\$3,500	\$2,500/\$3,500	\$1,500/\$2,500	\$2,500/\$3,500	\$1,500/\$2,500	Included w/ Med OOP Max	Included w/ Med OOP Max
Generic co-pay/30 days supply	\$0 at Costco \$9 at Other Network	\$0 at Costco \$9 at Other Network	\$0 at Costco \$7 at Other Network	\$0 at Costco \$9 at Other Network	\$0 at Costco \$7 at Other Network	Deductible, then \$0 at Costco or \$9 at Other Network	Deductible, then \$0 at Costco or \$9 at Other Network
Brand co-pay/30 days supply	\$35	\$35.00	\$25.00	\$35.00	\$25.00	Deductible, then \$35	Deductible, then \$35
Specialty co-pay/up to 30 days supply	\$35 Must Use Navitus Mail	\$35 Must Use Navitus Mail	\$25 Must Use Navitus Mail	\$35 Must Use Navitus Mail	\$25 Must Use Navitus Mail	Deductible, then \$35 (Must Use Navitus Mail)	Deductible, then \$35 (Must Use Navitus Mail)
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$90	\$0-\$90	\$0-\$60	\$0-\$90	\$0-\$60	Deductible, then \$0-\$90	Deductible, then \$0-\$90
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy

This sheet is only a brief summary of In-Network patient costs. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Out-of-Network services may not be covered. Employee cost/payroll deduction, if applicable, can be requested from the district.

*Coverage stages apply, see benefit summary for details