AUHSD Medical Plans
Summary of Benefits

SISC Self-Insured Schools of California — Schools Helping Schools — 2021-2022	Anthem	Anthem	Anthem	Kaiser
	Premier 10	90-G $20	80-G $20	Trad HMO $15
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0/$0	$500/$1,000	$500/$1,000	$0
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$1,000/$2,000	$1,000/$3,000	$2,000/$4,000	$1,500/$3,000
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	$15
Urgent Care co-pay	$10	$20	$20	$15
Specialists/Consultants co-pay	$10	$20	$20	$15
Prenatal, postnatal office visit co-pay	$10	$20	$20	$0
Scans: CT, CAT, MRI, PET etc.	$100/test	10%	20%	$0
Diagnostic X-ray & Laboratory Procedures	$0	10%	20%	$0
Infertility (diagnosis/treatment of causes of infertility subject to plan benefits)	50%	Not covered	Not covered	Co-pay applies
Preventive Care (includes physical exams & screenings)	$0	0% Ded Waived	0% Ded Waived	$0
HOSPITAL & SKILLED NURSING FACILITY SERVICES				
Emergency Room visit (waived if admitted)	$100	10% $100 co-pay	20% $100 co-pay	$100
Inpatient Hospital (preauthorization required) - limits may apply	$0	10%	20%	$0
Outpatient Hospital	$0	10%	20%	$15
Surgery, Outpatient (performed in Surgery Center)	$0	10%	20%	$15
Surgery, Outpatient (performed in a Hospital) - limits may apply	$0	10%	20%	$15
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT				
INPATIENT: Facility Based Care (preauth required)	$0	10%	20%	$0
OUTPATIENT: Facility Based Care (preauth required)	$0	10%	20%	$15
OTHER SERVICES				
Acupuncture - Limits apply	$10/30 visits combined w/chiro	10%	20%	$10/30 visits combined w/chiro
Ambulance (Ground or Air)	$100	10% $100 co-pay	20% $100 co-pay	$50
Chiropractic - Limits apply	$10/30 visits combined w/acu	10%	20%	$10/30 visits combined w/acu
Durable Medical Equipment (DME)	0%	10%	20%	no charge
Physical and Occupational Therapy - Limits apply	$10	10%	20%	$15
Hearing Aids	50% Coinsurance 1 device per ear/36 months	10% and Amount in excess of $700 allowance/24 months	20% and Amount in excess of $700 allowance/24 months	amount in excess of $500 allowance every 36 months
PHARMACY BENEFITS				
Plan	**5-20**	**5-20**	**5-20**	**Custom $5-$20 (30 day)**
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$1,500/$2,500	$1,500/$2,500	$1,500/$2,500	Included w/ Med OOP Max
Generic co-pay/30 days supply	$0 at Costco $5 at Other Network	$0 at Costco $5 at Other Network	$0 at Costco $5 at Other Network	$5 up to 30 day supply
Brand co-pay/30 days supply	$20	$20.00	$20.00	$20 up to 30 day supply
Specialty co-pay/up to 30 days supply	$20 Must Use Navitus Mail	$20 Must Use Navitus Mail	$20 Must Use Navitus Mail	$20 up to 30 day supply
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$50	$0-$50	$0-$50	$10-$40/up to 100 day supply
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Kaiser 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.