AUHSD Medical Plans
Summary of Benefits

SISC Self-Insured Schools of California *Schools Helping Schools* 2021-2022	Anthem HSA-A Individual	Anthem HSA-A Family	Kaiser HSA-A Single	Kaiser HSA-A Family
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	1500*	$2,800/$3,000*	$1,500*	$2,800/ $3,000*
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	3000*	$3,000/$6,000*	$3,000*	$3,000/$6,000*
	*Includes Rx	*Includes Rx	*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)	Deductible, then 10%	Deductible, then 10%	Deductible, then 10%	Deductible, then 10%
Urgent Care co-pay	10%	10%	10%	10%
Specialists/Consultants co-pay	10%	10%	10%	10%
Prenatal, postnatal office visit co-pay	10%	10%	$0	$0
Scans: CT, CAT, MRI, PET etc.	10%	10%	10%	10%
Diagnostic X-ray & Laboratory Procedures	10%	10%	10%	10%
Infertility (diagnosis/treatment of causes of infertility subject to plan benefits)	Not covered	Not covered	Co-pay applies	Co-pay applies
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES				
Emergency Room visit (waived if admitted)	10% $100 co-pay	10% $100 co-pay	10%	10%
Inpatient Hospital (preauthorization required) - limits may apply	10%	10%	10%	10%
Outpatient Hospital	10%	10%	10%	10%
Surgery, Outpatient (performed in Surgery Center)	10%	10%	10%	10%
Surgery, Outpatient (performed in a Hospital) - limits may apply	10%	10%	10%	10%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT				
INPATIENT: Facility Based Care (preauth required)	10%	10%	10%	10%
OUTPATIENT: Facility Based Care (preauth required)	10%	10%	10%	10%
OTHER SERVICES				
Acupuncture - Limits apply	10%	10%	Requires Prior Authorization	Requires Prior Authorization
Ambulance (Ground or Air)	10% $100 co-pay	10% $100 co-pay	10%	10%
Chiropractic - Limits apply	10%	10%	no coverage	no coverage
Durable Medical Equipment (DME)	10%	10%	10%	10%
Physical and Occupational Therapy - Limits apply	10%	10%	10%	10%
Hearing Aids	10% and Amount in excess of $700 allowance/24 months	10% and Amount in excess of $700 allowance/24 months	no coverage	no coverage
PHARMACY BENEFITS				
Plan	**HSA-A Rx Individual**	**HSA-A Rx Family**	**HSA A**	**HSA A**
Pharmacy Benefit Manager	Navitus	Navitus	Kaiser	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	Included w/	Included w/	Included w/	Included w/
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	Included w/ Med OOP Max	Included w/ Med OOP Max	Included w/ Med OOP Max	Included w/ Med OOP Max
Generic co-pay/30 days supply	Deductible, then	Deductible, then	deductible, then	deductible, then
Brand co-pay/30 days supply	Deductible, then	Deductible, then	deductible, then	deductible, then
Specialty co-pay/up to 30 days supply	Deductible, then	Deductible, then	deductible, then	deductible, then
Mail Order (Generic-Brand co-pay/90 days supply)	Deductible, then	Deductible, then	$20-$60/up to 100	$20-$60/up to 100
Mail Order Pharmacy	Costco Mail Order	Costco Mail Order	Kaiser Mail Order	Kaiser Mail Order

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.