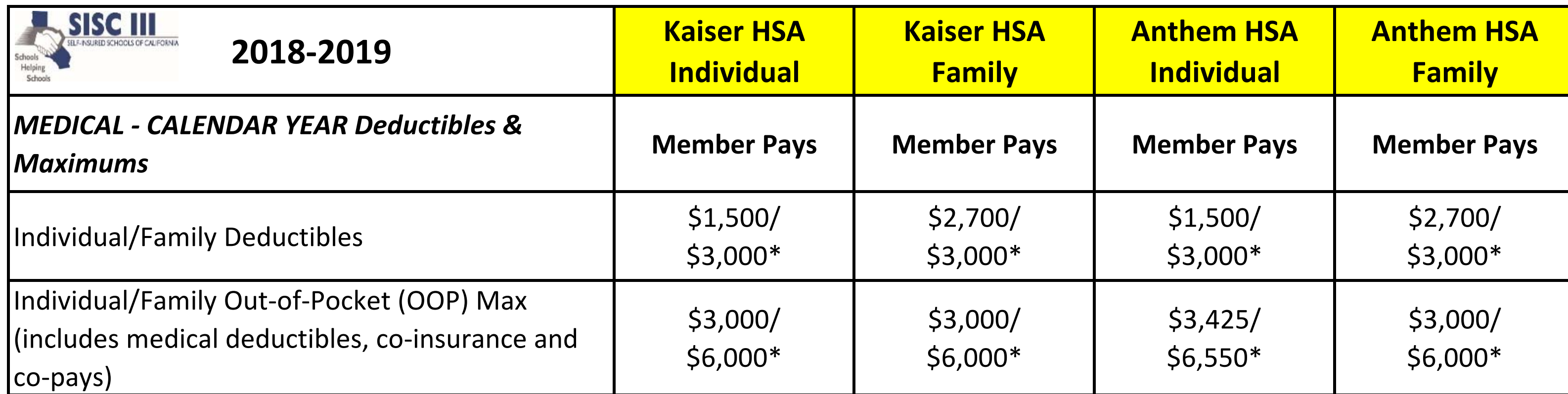
AUHSD HSA Plans
Summary of Benefits



SISC III 2018-2019	Kaiser HSA Individual	Kaiser HSA Family	Anthem HSA Individual	Anthem HSA Family
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$1,500/ $3,000*	$2,700/ $3,000*	$1,500/ $3,000*	$2,700/ $3,000*
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$3,000/ $6,000*	$3,000/ $6,000*	$3,425/ $6,550*	$3,000/ $6,000*
	***Includes Rx**	***Includes Rx**	***Includes Rx**	***Includes Rx**

PROFESSIONAL SERVICES

	Kaiser HSA Individual	Kaiser HSA Family	Anthem HSA Individual	Anthem HSA Family
Office Visit (OV) co-pay	10%	10%	10%	10%
Urgent Care co-pay	10%	10%	10%	10%
Specialists/Consultants co-pay	10%	10%	10%	10%
Prenatal, postnatal office visit co-pay	$0	$0	10%	10%
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)	OV copay or hospitalization copay apply	OV copay or hospitalization copay apply	Not covered	Not covered
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived

HOSPITAL & SKILLED NURSING FACILITY SERVICES

	Kaiser HSA Individual	Kaiser HSA Family	Anthem HSA Individual	Anthem HSA Family
Emergency Room visit (waived if admitted)	10%	10%	10% $100 co-pay	10% $100 co-pay
Inpatient Hospital (preauthorization required)	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)	10%	10%	10%	10%

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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	Limited coverage if authorized	Limited coverage if authorized	10%	10%
Ambulance (Ground or Air)	10%	10%	10% $100 co-pay	10% $100 co-pay
Chiropractic - Limits apply	Not covered	Not covered	10%	10%
Durable Medical Equipment (DME)	10%	10%	10%	10%
Physical and Occupational Therapy - Limits apply	10%	10%	10%	10%

PHARMACY BENEFITS

Individual/Family Brand & Specialty Rx Deductibles	Included w/ Medical ded	Included w/ Medical ded	Included w/ Medical ded	Included w/ Medical ded
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	$10 after deductible is met	$10 after deductible is met	$9	$9
Brand co-pay/30 days supply	$30 after deductible is met	$30 after deductible is met	$35	$35
Specialty co-pay/up to 30 days supply	$30 after deductible is met	$30 after deductible is met	Mail $35	Mail $35
Mail Order (Generic-Brand co-pay/90 days supply)	$20-$60/up to 100 day supply	$20-$60/up to 100 day supply	$0-$90	$0-$90