



CALIFORNIA SCHOOLS
VEBA

San Dieguito Union High School - Certificated

Effective Period: January 1, 2022 - December 31, 2022

No plan design changes for 2022

Benefit Summary	Kaiser HMO \$10, Rx: \$10/\$20 30-day (San Dieguito USD - Cert.) What You Pay	UHC Performance HMO Plan A, Network 1 What You Pay	UHC Performance HMO Plan A, Network 2 What You Pay	UHC Signature Value Alliance HMO \$20/\$30 What You Pay
Medical Deductible (individual/family)	None	None	None	None
Medical Out-of-Pocket Maximum (individual/family)	\$1,500 / \$3,000	\$1,500 / \$3,000	\$3,000 / \$6,000	\$3,000 / \$6,000
Health Account	None	None	None	None
PCP Office Visit	\$10 copay	\$10 copay	\$20 copay	\$20 copay
Specialist Office Visit	\$10 copay	\$10 copay	\$20 copay	\$30 copay
Preventive Care	No charge	No charge	No charge	No charge
Inpatient Hospital Care	No charge	No charge	No charge	\$500 admit copay
Mental Health Services (outpatient/inpatient)	\$10 copay / No charge	\$10 copay / No charge	\$20 copay / No charge	\$20 copay / \$500 admit copay
Substance Abuse Services (outpatient/inpatient)	\$10 copay / No charge	No charge	No charge	No charge
Outpatient Diagnostic Laboratory and Radiology (standard procedures)	No charge	No charge	No charge	No charge
Complex Radiology (PET & MRI)	No charge	No charge	No charge	\$200 copay
Outpatient Surgery	\$10 copay	No charge	No charge	\$250 copay
Outpatient Physical/Rehabilitation Therapy (Office Visit)	\$10 copay	\$10 copay	\$20 copay	\$20 copay
Chiropractic Services*	\$10 copay	\$10 copay	\$20 copay	\$20 copay
Urgent Care (your medical group/other medical group)	\$10 copay	\$10 copay / \$50 copay	\$20 copay / \$50 copay	\$20 copay / \$75 copay
Emergency Room (Copay waived if admitted)	\$75 copay	\$100 copay	\$100 copay	\$150 copay
Rx Deductible (individual/family)	None	None	None	None
Rx Out-of-Pocket Maximum (individual/family)	N/A	\$3,000 / \$6,000	\$3,000 / \$6,000	\$1,600 / \$3,200
Rx Formulary List	Kaiser	Performance	Performance	Performance
Rx Pharmacy Network	Kaiser	Express Advantage Network**	Express Advantage Network**	Express Advantage Network**
Short-Term Prescription Drugs*** (up to 30-day supply)	G: \$10 copay B: \$20 copay (up to a 30-day supply)	\$5 Generic \$25 PB 50% \$40 min \$175 max NPB	\$10 Generic \$30 PB 50% \$40 min \$175 max NPB	\$10 Generic \$30 PB 50% \$40 min \$175 max NPB
Long-Term Prescription Drugs*** (up to 90-day supply)	G: \$20 copay B: \$40 copay (up to a 100-day supply)	\$10 Generic \$50 PB 50% \$80 min \$350 max NPB	\$20 Generic \$60 PB 50% \$80 min \$350 max NPB	\$20 Generic \$60 PB 50% \$80 min \$350 max NPB

Infertility services are excluded/not covered under non-Kaiser HMO plans and are included/covered under Kaiser HMO (excluding Kaiser Bronze) plans, please see your policies for details.

*Chiropractic services have no annual visit maximums, must be medically necessary and may be subject to prior authorization from OptumHealth. This also applies to Acupuncture services if elected by your employer, as it is optional.

**Pay standard copays if you fill your prescription at an EAN Pharmacy (EAN Pharmacies include Rite Aid, Costco, Ralphs, Kmart, Vons, Heggen, Safeway, SuperValue, WinnDixie, Walmart, and many independent pharmacies) visit www.Express-scripts.com for a complete list of EAN pharmacies.

**Pay standard copays plus \$5/prescription if you fill your prescription at a non-EAN Pharmacy (Non-EAN Pharmacies include CVS, Walgreens, and certain independent pharmacies).

**You will pay the Retail Refill Allowance (RRA) penalty (equal to 2 times short-term medication copay for 30-day supply) if you fill long-term prescriptions at a network pharmacy other than Smart90.

**Copays waived for preferred generic hypertension and hypoglycemic purchased at mail or Smart 90. This does not include normal retail use or brand drugs.

***G = Generic, P = Preferred, B = Brand, PB = Preferred Brand, NPB = Non-preferred Brand, S = Specialty

Disclaimer: Prepared by Gallagher Benefit Services, Inc. on behalf of VEBA.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to your Human Resources/Benefits Department.



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United Healthcare Plan Summaries

Effective Period: January 1, 2022 - December 31, 2022

No plan design changes for 2022

Benefit Summary	Cigna Select HMO \$10 (San Dieguito USD) What You Pay	UMR CA Select Plus PPO 90/70, \$500	
		In Network What You Pay	Out of Network What You Pay
Medical Deductible (individual/family)	None	\$500 / \$1,000	\$500 / \$1,000
Medical Out-of-Pocket Maximum (individual/family)	\$1,000 / \$3,000	\$2,000 / \$4,000	\$4,000 / \$8,000
Health Account	None	None	
PCP Office Visit	\$10 copay	\$20 copay	30% coinsurance (after deductible)
Specialist Office Visit	\$10 copay	\$20 copay	30% coinsurance (after deductible)
Preventive Care	No charge	No charge	No coverage for non-network services
Inpatient Hospital Care	No charge	10% coinsurance (after deductible)	30% coinsurance (after deductible)
Mental Health Services (outpatient/inpatient)	\$10 copay / No charge	\$20 copay / 10% coinsurance (after deductible)	30% coinsurance (after deductible)
Substance Abuse Services (outpatient/inpatient)	\$10 copay / No charge	\$20 copay / 10% coinsurance (after deductible)	30% coinsurance (after deductible)
Outpatient Diagnostic Laboratory and Radiology (standard procedures) <i>Freestanding Facility or Physician Office OR</i>	No charge	No charge	30% coinsurance (after deductible)
<i>Hospital-based Lab or Radiology</i>	No charge	No charge	
Complex Radiology (PET & MRI) <i>Freestanding Facility or Physician Office OR</i>	No charge	10% coinsurance (after deductible)	30% coinsurance (after deductible)
<i>Hospital-based Complex Radiology</i>	No charge	10% coinsurance (after deductible)	
Outpatient Surgery <i>Ambulatory Surgery Center or Physician's Office</i>	No charge	10% coinsurance (after deductible)	30% coinsurance (after deductible)
<i>Outpatient Hospital-based Surgical Center</i>	No charge	10% coinsurance (after deductible)	
Outpatient Physical/Rehabilitation Therapy (Office Visit)	\$10 copay	\$20 copay	30% coinsurance (after deductible)
Chiropractic and Acupuncture Services*	\$10 copay** 20 days	\$20 copay	30% coinsurance (after deductible)
Urgent Care (office visit only)	\$10 copay	\$50 copay	30% coinsurance (after deductible)
Emergency Room (Copay waived if admitted)	\$100 copay	\$100 copay	\$100 copay
Rx Deductible (individual/family)	None	None	
Rx Out-of-Pocket Maximum (individual/family)	N/A	\$1,600 / \$3,200	
Rx Formulary List	Cigna	Performance	
Rx Pharmacy Network	Cigna	Express Advantage Network**	
Short-Term Prescription Drugs*** (up to 30-day supply)	G: \$10 P: \$20 NP/S: \$35	\$10 Generic \$30 PB 50% \$40 min \$175 max NPB	Retail: with submission of a paper claim, member will be reimbursed at the rate the Plan would have paid had the member used an in- network pharmacy less the member's copay.
Long-Term Prescription Drugs*** (up to 90-day supply)	G: \$20 P: \$40 NP/S: \$70	\$20 Generic \$60 PB 50% \$80 min \$350 max NPB	No coverage for non-network pharmacy

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*Chiropractic and Acupuncture services have no annual visit maximums, must be medically necessary and may be subject to prior authorization from OptumHealth for HMO, UMR for PPO, and Kaiser.

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