Your Summary of Benefits
Premier HMO

Premier HMO 10/100%

This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Annual copay maximum: Individual $1,500; Family $3,000

The following copay does not apply to the annual copay maximum: for infertility services

Covered Services	Per Member Copay
Preventive Care Services	
Preventive Care Services including*, physical exams, preventive screenings *(including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing)*, and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay
Smoking Cessation Program	No copay
Physician Medical Services	
• Office & home visits	$10/visit
• Specialists	$10/visit
• Skilled nursing facility visits	No copay
• Hospital visits	No copay
• Injectable medications in physician's office *(excluding allergy serum and immunization)*	20%/up to $150 maximum copay
• Surgeon & Surgical assistant	No copay
• Anesthesiologist or anesthetist	No copay
Acupuncture	$10/visit
Outpatient Medical Services (*Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital*)	
• Outpatient surgery & supplies	No copay
• Advanced Imaging	$100/test
• All other X-ray & laboratory tests (*including genetic testing*)	No copay
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	$10/visit
• Other Outpatient Medical Services including: Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy, limited to a 60-day period of care)*	$10/visit
General Medical Services (*when performed in non-hospital-based facility*)	
• Advanced Imaging	$100/test
• All other X-ray & laboratory tests (*including genetic testing*)	No copay
• Allergy testing & treatment *(including serums)*	$10/visit
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	$10/visit
• Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care)*	$10/visit
Emergency Care	
• Physician & medical services	No copay

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Covered Services	Per Member Copay
• Outpatient hospital emergency room services	$100/visit (*waived if admitted*)
Inpatient Medical Services Semi-private room or private room, medically necessary services & supplies	No copay
Urgent Care *(out of service area)*	$10/visit *(copay waived if admitted inpatient and outpatient ER. For in area, contact your PCP or medical group)*
Skilled Nursing Facility (*limited to 100 days/calendar year*) • All necessary services & supplies (*excluding take-home drugs*)	No copay
Ambulance Services • Transportation when medically necessary	$100/trip
Ambulatory Surgical Center • Outpatient surgery & supplies	No copay
Pregnancy and Maternity Care Prenatal & postnatal Professional *(physician)* services *(For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)* **Elective Abortions** *(including prescription drug for abortion, mifepristone)*	$10/visit $150
Prosthetic devices *(including Orthotics)*	No copay
Durable medical equipment • Rental and Purchase of DME *(breast pump and supplies are covered under preventive care at no charge)*	20%
Family Planning Services • Infertility studies & tests • Female Sterilization *(including tubal ligation and counseling/consultation)* • Male Sterilization • Counseling & consultation	50% of covered expense† No copay $50 $10/visit
Mental or Nervous Disorders and Substance Abuse **Inpatient Care** • Facility-based care (*pre-authorization required*) • Physician hospital visits **Outpatient Care** • Facility-based care (*pre-authorization required*) • Outpatient physician visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	 No copay No copay No copay $10/visit
Home Health Care (*limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less*)	$10/visit
Hospice Care (*Inpatient or outpatient services; family bereavement services*)	No copay
Organ and Tissue Transplant • Inpatient Care • Physician office visits • Specialist office visits	No copay $10/visit $10/visit

This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

† Not applicable to the annual copay maximum

Exclusions and Limitations

Care Not Approved. Care from a health care provider without the OK of primary care doctor, except for emergency services or urgent care.

Care Not Covered. Services before the member was on the plan, or after coverage ended.

Care Not Listed. Services not listed as being covered by this plan.

Care Not Needed. Any services or supplies that are not medically necessary.

Crime or Nuclear Energy. Any health problem caused: (1) while committing or trying to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) by nuclear energy, when the government can pay for treatment.

Experimental or Investigative. Any experimental or investigative procedure or medication.
But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may ask that the denial be reviewed by an external independent medical review organization, as described in the Evidence of Coverage (EOC).

Government Treatment. Any services the member actually received that were given by a local, state or federal government agency, except when this plan's benefits, must be provided by law.
We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services Given by Providers Who Are Not With Anthem Blue Cross HMO. We will not cover these services unless primary care doctor refers the member, except for emergencies or urgent care.

Services Not Needing Payment. Services the member is not required to pay for or are given to the member at no charge, except services the member got at a charitable research hospital (not with the government). This hospital must:1. Be known throughout the world as devoted to medical research.2. Have at least 10% of its yearly budget spent on research not directly related to patient care.3. Have 1/3 of its income from donations or grants (not gifts or payments for patient care).4. Accept patients who are not able to pay.5. Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).

Work-Related. Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Third Party Liability" below.

Acupressure. Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Birth Control Devices. Any devices needed for birth control which can be obtained without a doctor's prescription such as condoms.

Blood. Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

Braces or Other Appliances or Services for straightening the teeth (orthodontic services).

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Evidence of Coverage (EOC).

Commercial weight loss programs. Weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as covered in the EOC. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

Consultations given by telephone or fax.

Cosmetic Surgery. Surgery or other services done only to make the member: look beautiful; to improve appearance; or to change or reshape normal parts or tissues of the body. This does not apply to reconstructive surgery the member might need to: get back the use of a body part; have for breast reconstruction after a mastectomy; correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance. Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

Custodial Care or Rest Cures. Room and board charges for a hospital stay mostly for a change of scene or to make the member feel good. Services given by a rest home, a home for the aged, or any place like that.

Dental Services or Supplies. Dentures, bridges, crowns, caps, or dental prostheses, dental implants, dental services, tooth extraction, or treatment to the teeth or gums. Cosmetic dental surgery or other dental services for beauty purposes.

Diabetic Supplies. Prescription and non-prescription diabetic supplies, except as specified as covered in the EOC.

Eye Exercises or Services and Supplies for Correcting Vision. Optometry services, eye exercises, and orthoptics, except for eye exams to find out if the member's vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.

Eye Surgery for Refractive Defects. Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as specified as covered in the EOC or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Health Club Membership. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a doctor. This exclusion also applies to health spas.

Hearing Aids. Hearing aids or services for fitting or making a hearing aid, except as specified as covered in the EOC.

Immunizations. Immunizations needed to travel outside the USA.

Infertility Treatment. Any infertility treatment including artificial insemination or in vitro fertilization & sperm bank.

Lifestyle Programs. Programs to help member change how one lives, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by the medical group.

Mental or nervous disorders. Academic or educational testing, counseling. Remedying an academic or education problem, except as stated as covered in the EOC.

Nicotine Use. Programs to stop smoking or the treatment of nicotine or tobacco use if the program is not affiliated with Anthem.

Non-Prescription Drugs. Non-prescription, over-the-counter drugs or medicines, except as specified as covered in the Evidence of Coverage (EOC).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Outpatient Drugs. Outpatient prescription drugs or medications including insulin.

Personal Care and Supplies. Services for personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Routine Exams. Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

Sexual Problems. Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

Sterilization Reversal. Surgery done to reverse a sterilization.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Third Party Liability – Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Coordination of Benefits – The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

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Hearing Aid Rider

This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

What Is Covered

Hearing Aid Services

This benefit covers one medically necessary hearing aid every three years when ordered by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist. The member is responsible for **50%** coinsurance. Member coinsurance is included in the annual out of pocket max.

Covered services include:

- Audiological evaluations to:
  - measure the extent of hearing loss; and
  - determine the most appropriate make and model of hearing aid.

These evaluations will be covered under the plan benefits for office visits to doctors.

- Hearing aids (monaural or binaural) including:
  - ear mold(s), the hearing aid instrument; and
  - batteries, cords and other ancillary equipment.
- Visits for fitting, counseling, adjustments and repairs for the covered hearing aid.

What Is Not Covered

Hearing Aid Services

The benefit does not include the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss;
2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). Medically necessary surgically implanted hearing devices may be covered under your plan's benefits for prosthetic devices (see "Prosthetic Devices"); or
3. Charges for a hearing aid which is not determined to be medically necessary.

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Chiropractic Care and Acupuncture Rider Plan 10/30

The benefits described in this Rider are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California (ASH Plans). The services listed below are covered only if provided by an ASH Plans Chiropractor and/or ASH Plans Acupuncturist. These benefits are provided in addition to the benefits described in the Anthem Blue Cross HMO Evidence of Coverage (EOC) document. However, when expenses are incurred for treatment received from an ASH Plans Chiropractor or ASH Plans Acupuncturist, no other benefits other than the benefits described in this Rider will be paid.

Covered Services	Member's Copayment
Office Visit to a Chiropractor or Acupuncturist	$10/visit
Maximum Benefits	
Office visits to a Chiropractor or Acupuncturist	30 visits per calendar year (chiropractic and acupuncture visits combined)
Chiropractic appliances	$50 per calendar year

Covered Services

Chiropractor Services: Member has up to 30 visits, combined with visits for acupuncture services, in a calendar year for chiropractor care services that are determined by ASH PLANS to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans chiropractor to determine the appropriateness of chiropractic services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans chiropractor
- An established patient exam performed by an ASH Plans chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans chiropractor.
- Radiological x-rays and laboratory tests when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered services include radiological consultations when determined by ASH Plans to be medically/clinically necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Plans to provide those services.
- **Chiropractic Appliances:** Up to $50 per calendar year when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered chiropractic appliances are limited to:
  - elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports;
  - cervical collars or cervical pillows;
  - ankle braces, knee braces, or wrist braces;
  - heel lifts;
  - hot or cold packs;
  - lumbar cushions;
  - rib belts or orthotics; and
  - home traction units for treatment of the cervical or lumbar regions.

Acupuncture Services. Member has up to 30 visits, combined with visits for chiropractic care, in a calendar year for acupuncture services that are determined by ASH Plans to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans acupuncturist is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans acupuncturist to determine the appropriateness of acupuncture services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans acupuncturist
- An established patient exam performed by an ASH Plans acupuncturist to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans acupuncturist.

Chiropractic Care and Acupuncture Rider Exclusions & Limitations

Care Not Approved: Any services provided by an ASH Plans chiropractor or an ASH Plans acupuncturist that are not approved by ASH Plans except as specified as covered in the Evidence of Coverage (EOC). An ASH Plans chiropractor or ASH Plans acupuncturist is responsible for submitting a treatment plan to ASH Plans for prior approval.

Care Not Covered: In addition to any service or supply specifically excluded in the EOC, no benefits will be provided for chiropractic or acupuncture services or supplies in connection with:

- Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans. Diagnostic services for acupuncture.
- Thermography.
- Hypnotherapy.
- Behavior training.
- Sleep therapy.
- Weight programs.
- Any non-medical program or service.
- Pre-employment examinations, any chiropractic or acupuncture services required by an employer that are not medically/clinically necessary, or vocational rehabilitation.
- Services and/or treatments which are not documented as medically/clinically necessary.
- Massage therapy.
- Acupuncture performed with reusable needles.
- Acupuncture services benefits are not provided for magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
- Any service or supply for the exam and/or treatment by an ASH chiropractor for conditions other than those related to neuromusculoskeletal disorders.
- Services from an ASH Plans acupuncturist for exam and/or treatment for conditions not related to neuromusculoskeletal disorders, nausea or pain, incluing, without limitation, asthma or addictions such as nicotine addiction.
- Transportation costs including local ambulance charges.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services;
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephone compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.
- Laboratory and diagnostic x-ray studies, except as specified as covered in the EOC.

Non-ASH Plans Chiropractors or non-ASH Plans Acupuncturists: Services and supplies provided by a chiropractor or an acupuncturists who does not have an agreement with ASH Plans to provide covered services under this plan.

Work Related: Care for health problems that are work-related if such health problems are covered by workers' compensation, an employer's liability law or similar law. We will provide care for a work-related health problem, but we have the right to be paid back for that care as described in the EOC.

Government Treatment: Any services actually given to the member by a local, state or federal government agency, except when this plan's benefits, must be provided by law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Drugs: Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription.

Supplement. Vitamins, minerals, dietary and nutritional supplements or other similar products and any herbal supplements.

Air Conditioners: Air purifiers, air conditioners, humidifiers, supplies or any other similar devices or appliances. All appliances or durable medical equipment, except as specified as covered in the EOC..

Personal Items: Any supplies for comfort, hygiene or beauty purposes, including therapeutic mattresses.

Out-Of-Area and Emergency Care: Out-of-area care is not covered under this Chiropractic and Acupuncture Care benefit, except for emergency services. The member should follow the procedures specified by their Anthem Blue Cross HMO plan to obtain emergency or out-of-area care.

Third Party Liability

Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

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Self-Insured Schools of California (SISC)
Pharmacy Benefit Schedule

Benefit Effective Date				
October 1, 2014				
Benefit Type				
Participating Pharmacy ***Costco Retail***			Up to 30 Days Up to 90 Days	
Costco Mail Order			Up to 90 Days	
Benefit Structure				
Level	***Costco Retail Pharmacy 30 day***	**Costco Retail Pharmacy 90 day**	***Other Retail Pharmacy 30 day***	***Costco Mail Order 90 day***
Generic	$0	$0	$7	$0
Brand	$25	$60	$25	$60
Annual Out-of-Pocket Maximum				
Individual Maximum			$6,350	
Family Maximum			$12,700	
Additional Coverage Information				

- Up to a 90 day supply of generic medications are free at Costco retail and mail order pharmacies; specialty, narcotic pain and cough medications are not included. Some narcotic pain medications and cough medications require the regular retail copay at Costco and 3 times the regular retail copay at Mail.
- Fill a 90 day supply of brand medication at Costco and pay the mail order copay.
- Diabetic supplies are only available as brand prescriptions and not generic.

However, the SISC pharmacy plans charge the generic copay on preferred brand supplies (lancets, pen needles, test strips and syringes).

- SISC urges members to use generic drugs when they are available. If you or your physician requests the brand name when a generic equivalent is available, you will pay the generic copay plus the difference in cost between the brand and generic. The difference in cost between the brand and generic will not count toward the Annual Out-of-Pocket Maximum.

Mail Order Service

The Mail Order Service allows you to receive a 90-day supply of maintenance medications. This program is part of your pharmacy benefit and is **voluntary**.

Specialty Pharmacy

Navitus SpecialtyRx helps members who are taking medications for certain chronic illnesses or complex diseases by providing services that offer convenience and support. This program is part of your pharmacy benefit and is **mandatory**.

Your Summary of Benefits
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Premier HMO 20

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Annual copay maximum: Individual $1,500; Family $3,000

The following copay does not apply to the annual copay maximum: for infertility services

Covered Services	Per Member Copay
Preventive Care Services	
Preventive Care Services including*, physical exams, preventive screenings *(including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing),* and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay
Smoking Cessation Program	No copay
Physician Medical Services	
• Office & home visits	$20/visit
• Specialists	$20/visit
• Skilled nursing facility visits	No copay
• Hospital visits	No copay
• Injectable medications in physician's office *(excluding allergy serum and immunization)*	20%/up to $150 maximum copay
• Surgeon & Surgical assistant	No copay
• Anesthesiologist or anesthetist	No copay
Acupuncture	$20/visit
Outpatient Medical Services (*Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital*)	
• Outpatient surgery & supplies	$100/admit
• Advanced Imaging	$100/test
• All other X-ray & laboratory tests (*including genetic testing*)	No copay
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	$20/visit
• Other Outpatient Medical Services including: Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy, limited to a 60-day period of care)*	$20/visit
General Medical Services (*when performed in non-hospital-based facility*)	
• Advanced Imaging	$100/test
• All other X-ray & laboratory tests (*including genetic testing*)	No copay
• Allergy testing & treatment *(including serums)*	$20/visit
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	$20/visit
• Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care)*	$20/visit
Emergency Care	
• Physician & medical services	No copay

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Covered Services	Per Member Copay
◦ Outpatient hospital emergency room services	$100/visit (*waived if admitted inpatient*)
Inpatient Medical Services Semi-private room or private room, medically necessary services & supplies	$200/admit
Urgent Care *(out of service area)*	$20/visit *(copay waived if admitted inpatient and outpatient ER. For in area, contact your PCP or medical group)*
Skilled Nursing Facility (*limited to 100 days/calendar year*) ◦ All necessary services & supplies (*excluding take-home drugs*)	No copay
Ambulance Services ◦ Transportation when medically necessary	$100/trip
Ambulatory Surgical Center ◦ Outpatient surgery & supplies	$100/admit
Pregnancy and Maternity Care Prenatal & postnatal Professional *(physician)* services *(For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)* **Elective Abortions** *(including prescription drug for abortion, mifepristone)*	$20/visit $150
Prosthetic devices *(including Orthotics)*	No copay
Durable medical equipment ◦ Rental and Purchase of DME *(breast pump and supplies are covered under preventive care at no charge)*	20%
Family Planning Services ◦ Infertility studies & tests ◦ Female Sterilization *(including tubal ligation and counseling/consultation)* ◦ Male Sterilization ◦ Counseling & consultation	50% of covered expense† No copay $50 $20/visit
Mental or Nervous Disorders and Substance Abuse **Inpatient Care** ◦ Facility-based care (*pre-authorization required*) ◦ Physician hospital visits **Outpatient Care** ◦ Facility-based care (*pre-authorization required*) ◦ Outpatient physician visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	$200/admit No copay No copay $20/visit
Home Health Care (*limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less*)	$20/visit
Hospice Care (*Inpatient or outpatient services; family bereavement services*)	No copay
Organ and Tissue Transplant ◦ Inpatient Care ◦ Physician office visits ◦ Specialist office visits	$200/admit $20/visit $20/visit

This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

† Not applicable to the annual copay maximum

Exclusions and Limitations

Care Not Approved. Care from a health care provider without the OK of primary care doctor, except for emergency services or urgent care.

Care Not Covered. Services before the member was on the plan, or after coverage ended.

Care Not Listed. Services not listed as being covered by this plan.

Care Not Needed. Any services or supplies that are not medically necessary.

Crime or Nuclear Energy. Any health problem caused: (1) while committing or trying to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) by nuclear energy, when the government can pay for treatment.

Experimental or Investigative. Any experimental or investigative procedure or medication.
But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may ask that the denial be reviewed by an external independent medical review organization, as described in the Evidence of Coverage (EOC).

Government Treatment. Any services the member actually received that were given by a local, state or federal government agency, except when this plan's benefits, must be provided by law.
We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services Given by Providers Who Are Not With Anthem Blue Cross HMO. We will not cover these services unless primary care doctor refers the member, except for emergencies or urgent care.

Services Not Needing Payment. Services the member is not required to pay for or are given to the member at no charge, except services the member got at a charitable research hospital (not with the government). This hospital must:1. Be known throughout the world as devoted to medical research.2. Have at least 10% of its yearly budget spent on research not directly related to patient care.3. Have 1/3 of its income from donations or grants (not gifts or payments for patient care).4. Accept patients who are not able to pay.5. Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).

Work-Related. Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Third Party Liability" below.

Acupressure. Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Birth Control Devices. Any devices needed for birth control which can be obtained without a doctor's prescription such as condoms.

Blood. Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

Braces or Other Appliances or Services for straightening the teeth (orthodontic services).

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Evidence of Coverage (EOC).

Commercial weight loss programs. Weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as covered in the EOC. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

Consultations given by telephone or fax.

Cosmetic Surgery. Surgery or other services done only to make the member: look beautiful; to improve appearance; or to change or reshape normal parts or tissues of the body. This does not apply to reconstructive surgery the member might need to: get back the use of a body part; have for breast reconstruction after a mastectomy; correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance. Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

Custodial Care or Rest Cures. Room and board charges for a hospital stay mostly for a change of scene or to make the member feel good. Services given by a rest home, a home for the aged, or any place like that.

Dental Services or Supplies. Dentures, bridges, crowns, caps, or dental prostheses, dental implants, dental services, tooth extraction, or treatment to the teeth or gums. Cosmetic dental surgery or other dental services for beauty purposes.

Diabetic Supplies. Prescription and non-prescription diabetic supplies, except as specified as covered in the EOC.

Eye Exercises or Services and Supplies for Correcting Vision. Optometry services, eye exercises, and orthoptics, except for eye exams to find out if the member's vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.

Eye Surgery for Refractive Defects. Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as specified as covered in the EOC or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Health Club Membership. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a doctor. This exclusion also applies to health spas.

Hearing Aids. Hearing aids or services for fitting or making a hearing aid, except as specified as covered in the EOC.

Immunizations. Immunizations needed to travel outside the USA.

Infertility Treatment. Any infertility treatment including artificial insemination or in vitro fertilization & sperm bank.

Lifestyle Programs. Programs to help member change how one lives, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by the medical group.

Mental or nervous disorders. Academic or educational testing, counseling. Remedying an academic or education problem, except as stated as covered in the EOC.

Nicotine Use. Programs to stop smoking or the treatment of nicotine or tobacco use if the program is not affiliated with Anthem.

Non-Prescription Drugs. Non-prescription, over-the-counter drugs or medicines, except as specified as covered in the Evidence of Coverage (EOC).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Outpatient Drugs. Outpatient prescription drugs or medications including insulin.

Personal Care and Supplies. Services for personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Routine Exams. Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

Sexual Problems. Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

Sterilization Reversal. Surgery done to reverse a sterilization.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Third Party Liability – Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Coordination of Benefits – The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

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Hearing Aid Rider

This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

What Is Covered

Hearing Aid Services

This benefit covers one medically necessary hearing aid every three years when ordered by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist. The member is responsible for **50%** coinsurance. Member coinsurance is included in the annual out of pocket max.

Covered services include:

- Audiological evaluations to:
  - measure the extent of hearing loss; and
  - determine the most appropriate make and model of hearing aid.

These evaluations will be covered under the plan benefits for office visits to doctors.

- Hearing aids (monaural or binaural) including:
  - ear mold(s), the hearing aid instrument; and
  - batteries, cords and other ancillary equipment.
- Visits for fitting, counseling, adjustments and repairs for the covered hearing aid.

What Is Not Covered

Hearing Aid Services

The benefit does not include the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss;
2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). Medically necessary surgically implanted hearing devices may be covered under your plan's benefits for prosthetic devices (see "Prosthetic Devices"); or
3. Charges for a hearing aid which is not determined to be medically necessary.

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Chiropractic Care and Acupuncture Rider Plan 10/30

The benefits described in this Rider are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California (ASH Plans). The services listed below are covered only if provided by an ASH Plans Chiropractor and/or ASH Plans Acupuncturist. These benefits are provided in addition to the benefits described in the Anthem Blue Cross HMO Evidence of Coverage (EOC) document. However, when expenses are incurred for treatment received from an ASH Plans Chiropractor or ASH Plans Acupuncturist, no other benefits other than the benefits described in this Rider will be paid.

Covered Services	Member's Copayment
Office Visit to a Chiropractor or Acupuncturist	$10/visit
Maximum Benefits	
Office visits to a Chiropractor or Acupuncturist	30 visits per calendar year (chiropractic and acupuncture visits combined)
Chiropractic appliances	$50 per calendar year

Covered Services

Chiropractor Services: Member has up to 30 visits, combined with visits for acupuncture services, in a calendar year for chiropractor care services that are determined by ASH PLANS to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans chiropractor to determine the appropriateness of chiropractic services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans chiropractor
- An established patient exam performed by an ASH Plans chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans chiropractor.
- Radiological x-rays and laboratory tests when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered services include radiological consultations when determined by ASH Plans to be medically/clinically necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Plans to provide those services.
- **Chiropractic Appliances:** Up to $50 per calendar year when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered chiropractic appliances are limited to:
  - elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports;
  - cervical collars or cervical pillows;
  - ankle braces, knee braces, or wrist braces;
  - heel lifts;
  - hot or cold packs;
  - lumbar cushions;
  - rib belts or orthotics; and
  - home traction units for treatment of the cervical or lumbar regions.

Acupuncture Services. Member has up to 30 visits, combined with visits for chiropractic care, in a calendar year for acupuncture services that are determined by ASH Plans to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans acupuncturist is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans acupuncturist to determine the appropriateness of acupuncture services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans acupuncturist
- An established patient exam performed by an ASH Plans acupuncturist to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans acupuncturist.

Chiropractic Care and Acupuncture Rider Exclusions & Limitations

Care Not Approved: Any services provided by an ASH Plans chiropractor or an ASH Plans acupuncturist that are not approved by ASH Plans except as specified as covered in the Evidence of Coverage (EOC). An ASH Plans chiropractor or ASH Plans acupuncturist is responsible for submitting a treatment plan to ASH Plans for prior approval.

Care Not Covered: In addition to any service or supply specifically excluded in the EOC, no benefits will be provided for chiropractic or acupuncture services or supplies in connection with:

- Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans. Diagnostic services for acupuncture.
- Thermography.
- Hypnotherapy.
- Behavior training.
- Sleep therapy.
- Weight programs.
- Any non-medical program or service.
- Pre-employment examinations, any chiropractic or acupuncture services required by an employer that are not medically/clinically necessary, or vocational rehabilitation.
- Services and/or treatments which are not documented as medically/clinically necessary.
- Massage therapy.
- Acupuncture performed with reusable needles.
- Acupuncture services benefits are not provided for magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
- Any service or supply for the exam and/or treatment by an ASH chiropractor for conditions other than those related to neuromusculoskeletal disorders.
- Services from an ASH Plans acupuncturist for exam and/or treatment for conditions not related to neuromusculoskeletal disorders, nausea or pain, incluing, without limitation, asthma or addictions such as nicotine addiction.
- Transportation costs including local ambulance charges.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services;
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephone compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.
- Laboratory and diagnostic x-ray studies, except as specified as covered in the EOC.

Non-ASH Plans Chiropractors or non-ASH Plans Acupuncturists: Services and supplies provided by a chiropractor or an acupuncturists who does not have an agreement with ASH Plans to provide covered services under this plan.

Work Related: Care for health problems that are work-related if such health problems are covered by workers' compensation, an employer's liability law or similar law. We will provide care for a work-related health problem, but we have the right to be paid back for that care as described in the EOC.

Government Treatment: Any services actually given to the member by a local, state or federal government agency, except when this plan's benefits, must be provided by law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Drugs: Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription.

Supplement. Vitamins, minerals, dietary and nutritional supplements or other similar products and any herbal supplements.

Air Conditioners: Air purifiers, air conditioners, humidifiers, supplies or any other similar devices or appliances. All appliances or durable medical equipment, except as specified as covered in the EOC..

Personal Items: Any supplies for comfort, hygiene or beauty purposes, including therapeutic mattresses.

Out-Of-Area and Emergency Care: Out-of-area care is not covered under this Chiropractic and Acupuncture Care benefit, except for emergency services. The member should follow the procedures specified by their Anthem Blue Cross HMO plan to obtain emergency or out-of-area care.

Third Party Liability

Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

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Self-Insured Schools of California (SISC)
Pharmacy Benefit Schedule

Benefit Effective Date				
October 1, 2014				
Benefit Type				
Participating Pharmacy ***Costco Retail***			Up to 30 Days Up to 90 Days	
Costco Mail Order			Up to 90 Days	
Benefit Structure				
Level	***Costco Retail Pharmacy 30 day***	**Costco Retail Pharmacy 90 day**	***Other Retail Pharmacy 30 day***	***Costco Mail Order 90 day***
Generic	$0	$0	$7	$0
Brand	$25	$60	$25	$60
Annual Out-of-Pocket Maximum				
Individual Maximum			$6,350	
Family Maximum			$12,700	
Additional Coverage Information				

- Up to a 90 day supply of generic medications are free at Costco retail and mail order pharmacies; specialty, narcotic pain and cough medications are not included. Some narcotic pain medications and cough medications require the regular retail copay at Costco and 3 times the regular retail copay at Mail.
- Fill a 90 day supply of brand medication at Costco and pay the mail order copay.
- Diabetic supplies are only available as brand prescriptions and not generic.

However, the SISC pharmacy plans charge the generic copay on preferred brand supplies (lancets, pen needles, test strips and syringes).

- SISC urges members to use generic drugs when they are available. If you or your physician requests the brand name when a generic equivalent is available, you will pay the generic copay plus the difference in cost between the brand and generic. The difference in cost between the brand and generic will not count toward the Annual Out-of-Pocket Maximum.

Mail Order Service

The Mail Order Service allows you to receive a 90-day supply of maintenance medications. This program is part of your pharmacy benefit and is **voluntary**.

Specialty Pharmacy

Navitus SpecialtyRx helps members who are taking medications for certain chronic illnesses or complex diseases by providing services that offer convenience and support. This program is part of your pharmacy benefit and is **mandatory**.

Anthem Blue Cross

Your Summary of Benefits
SISC 80-G $30 Anthem Classic PPO

This Summary of Benefits is a brief overview of your plan's benefits only. The benefits listed are for both in state and out of state members, there may be differences in benefits depending on where you reside. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.
In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Subject to Utilization Review

Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

PPO Providers—The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-PPO Providers—For non-emergency care, reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount.

For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers *(4th quarter carryover applies)*	$500/member; $1,000/family
Co-pay for emergency room services	$100/visit ***(waived if admitted directly from ER)***
Annual Out-of-Pocket Maximums	
PPO Providers	$2,000/member; $4,000/family

**Member copayments and coinsurance for Emergency Medical Care with a Non-PPO Provider also apply to the PPO Out-of-Pocket Maximums.*

The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for costs in excess of the covered expense.

Lifetime Maximum **Unlimited**

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Preventive Care Services		
Preventive Care Services including*, physical exams, preventive screenings ***(including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.***	No copay ***(deductible waived)***	Not covered
Physician Medical Services		
• Office & home visits	$30/visit[2] ***(deductible waived)***	See footnote 1
• Hospital & skilled nursing facility visits	20%	See footnote 1
• Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	See footnote 1
• Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	20%	See footnote 1
Diabetes Education Programs ***(requires physician supervision)***		
• Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$30/visit[2] ***(deductible waived)***	See footnote 1

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(subject to medical necessity review administered by American Specialty Health- ASH)*	20%	See footnote 1
Speech Therapy • Outpatient speech therapy	20%	See footnote 1
Acupuncture [3] • Services for the treatment of disease, illness or injury *(limited to 12 visits/calendar year)*	20%	50% of maximum allowed amount[5]
Diagnostic X-ray & Lab • Other diagnostic x-ray & lab	20%	See footnote 1
Advanced Imaging ***(subject to utilization review)*** • MRI, CT Scan, PET Scan & nuclear cardiac exam	20%	See footnote 1 *(benefit limited to $800/procedure)*
Urgent Care ***(physician services)***	$30/visit[2] ***(deductible waived)***	See footnote 1
Emergency Care • Emergency room services & supplies *($100 co-pay waived if admitted inpatient)* [4] • Inpatient hospital services & supplies [4] • Physician services [4]	20% 20% 20%	20% of maximum allowed amount for true emergency[5] 20% first 48 hours[5]; After 48 hours: all billed amounts exceeding $600/day unless member cannot be moved safely 20% of maximum allowed amount for true emergency[5]
Hospital Medical Services ***(subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)*** • Semi-private room, medically necessary services & supplies • Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)* • Single Hip or Knee Joint Replacement Surgery – up to $30,000 per surgery. Travel expense when member's home is 50 miles or more from a low cost facility. ($3,000 maximum travel benefit per surgery)	20% 20% 20%	All billed amounts exceeding $600/day 50% of maximum allowed amount[5] All billed amounts exceeding $600/day
Skilled Nursing Facility (subject to utilization review) • Semi-private room, services & supplies (limited to 100 days/calendar year)	20%	All billed amounts exceeding $600/day
Related Outpatient Medical Services & Supplies[5] • Ground or air ambulance transportation, services & disposable supplies *(air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to $50,000 for non-PPO)* • Blood transfusions, blood processing & the cost of unreplaced blood & blood products • Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	20% 20% 20%	20% maximum allowed amount for true emergency[5] 20% maximum allowed amount[5] 20% maximum allowed amount[5]
Ambulatory Surgical Centers ***(certain surgeries are subject to utilization review)*** • Outpatient surgery, services & supplies	20%	All billed amounts exceeding $350/day
Pregnancy & Maternity Care • Physician office visits • Prescription drug for elective abortion *(mifepristone)* Normal delivery, cesarean section, complications of pregnancy & abortion. Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.	$30/visit[2] ***(deductible waived)*** 20%	See footnote 1 See footnote 1
Mental or Nervous Disorders and Substance Abuse Inpatient Care • Facility-based care *(subject to utilization review; waived for emergency admissions)* • Inpatient physician visits	20% 20%	All billed amounts exceeding $600/day See footnote 1

CONTINUED ON NEXT PAGE

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay†
Outpatient Care • Facility-based care *(subject to utilization review; waived for emergency admissions)* • Outpatient physician visits	20% $30/visit[2]	50% of maximum allowed amount[5] See footnote 1
Durable Medical Equipment ***(may be subject to utilization review)*** • Rental or purchase of DME *(breast pump and supplies are covered under preventive care at no charge for in-network only)* • Hearing aid supplies and equipment (limited to $700 per 24 months)	20% 20%	See footnote 1 See footnote 1
Home Health Care ***(subject to utilization review)*** • Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	See footnote 1
Home Infusion Therapy ***(subject to utilization review)*** • Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	All billed amounts exceeding $600/day
Hemodialysis • Outpatient hemodialysis services & supplies	20%	All billed amounts exceeding $350/visit
Hospice Care • Inpatient or outpatient services; family bereavement services	No copay ***(deductible waived)***	All billed amounts exceeding the maximum allowed amount
Bariatric Surgery ***(subject to utilization review; covered only when performed at a Centers of Medical Excellence [CME])*** • Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity • Travel expenses when member's home is 50 miles or more from the nearest Bariatric CME *($3,000 maximum travel benefit per surgery)*	20% No copay ***(deductible waived)***	Not covered Not covered
Organ & Tissue Transplants ***(subject to utilization review; specified transplants covered only when performed at a Centers of Medical Excellence [CME])*** • Inpatient services provided in connection with non-investigative organ or tissue transplants • Transplant travel expense for an authorized, specified transplant *(recipient & companion transportation limited to $10,000 per transplant)* • Unrelated donor search, limited to $30,000 per transplant	20% No copay ***(deductible waived)***	Not covered Not covered
Prosthetic Devices • Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes	20%	See footnote 1

Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense. This Summary of Benefits has been updated to comply with federal requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

1 The plan pays 100% of the fee schedule. The member is responsible for all amounts exceeding the fee schedule.

2 The dollar copay applies only to the visit itself. An additional copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

3 Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

4 The allowable rate for non-PPO emergency care within 48 hours is based on a reasonable charge, not the scheduled amount.

5 These providers may not be represented in the PPO network in the state where the member receives services. Reimbursements for these non-PPO providers are based on a reasonable charge, not the scheduled amount.

Classic PPO Plan-Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.
Excess Amounts. Any amounts in excess of covered expense or any medical benefit maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines: 1. It must be internationally known as being devoted mainly to medical research; 2. At least 10% of its yearly budget must be spent on research not directly related to patient care; 3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care; 4. It must accept patients who are unable to pay; and 5. Two-thirds of its patients must have conditions directly related to the hospital's research.
Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:
1. Extraction, restoration, and replacement of teeth; 2. Services to improve dental clinical outcomes. This exclusion does not apply to the following:
1. Services which we are required by law to cover; 2. Services specified as covered in this booklet;
3. Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.
Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the EOC.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.
Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal. Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications as specified as covered in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Private duty nursing services.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Wigs.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.
Coordination of Benefits — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Companies an independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Self-Insured Schools of California (SISC)
Pharmacy Benefit Schedule

Benefit Effective Date				
October 1, 2014				
Benefit Type				
Participating Pharmacy			Up to 30 Days	
Costco Retail			Up to 90 Days	
Costco Mail Order			Up to 90 Days	
Benefit Structure				
Level	***Costco Retail Pharmacy 30 day***	**Costco Retail Pharmacy 90 day**	***Other Retail Pharmacy 30 day***	***Costco Mail Order 90 day***
Generic	$0	$0	$9	$0
Brand	$35	$90	$35	$90
Annual Out-of-Pocket Maximum				
Individual Maximum			$6,350	
Family Maximum			$12,700	
Additional Coverage Information				

- Up to a 90 day supply of generic medications are free at Costco retail and mail order pharmacies; specialty, narcotic pain and cough medications are not included. Some narcotic pain medications and cough medications require the regular retail copay at Costco and 3 times the regular retail copay at Mail.
- Fill a 90 day supply of brand medication at Costco retail and pay the mail order copay.

- Diabetic supplies are only available as brand prescriptions and not generic. However, the SISC pharmacy plans charge the generic copay on preferred brand supplies (lancets, pen needles, test strips and syringes).
- SISC urges members to use generic drugs when they are available. If you or your physician requests the brand name when a generic equivalent is available, you will pay the generic copay plus the difference in cost between the brand and generic. The difference in cost between the brand and generic will not count toward the Annual Out-of-Pocket Maximum.

Mail Order Service

The Mail Order Service allows you to receive a 90-day supply of maintenance medications. This program is part of your pharmacy benefit and is **voluntary.**

Specialty Pharmacy

Navitus SpecialtyRx helps members who are taking medications for certain chronic illnesses or complex diseases by providing services that offer convenience and support. This program is part of your pharmacy benefit and is **mandatory**.

Anthem Blue Cross

Your Summary of Benefits
SISC 80-G $20 Anthem Classic PPO

This Summary of Benefits is a brief overview of your plan's benefits only. The benefits listed are for both in state and out of state members, there may be differences in benefits depending on where you reside. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.
In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Subject to Utilization Review

Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

PPO Providers—The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-PPO Providers—For non-emergency care, reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount.

For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers — $500/member; $1,000/family
(4th quarter carryover applies)

Co-pay for emergency room services — $100/visit ***(waived if admitted directly from ER)***

Annual Out-of-Pocket Maximums

PPO Providers — $2,000/member; $4,000/family
**Member copayments and coinsurance for Emergency Medical Care with a Non-PPO Provider also apply to the PPO Out-of-Pocket Maximums.*

The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for costs in excess of the covered expense.

Lifetime Maximum — **Unlimited**

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Preventive Care Services		
Preventive Care Services including*, physical exams, preventive screenings ***(including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.***	No copay ***(deductible waived)***	Not covered
Physician Medical Services		
• Office & home visits	$20/visit[2] ***(deductible waived)***	See footnote 1
• Hospital & skilled nursing facility visits	20%	See footnote 1
• Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	See footnote 1
• Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	20%	See footnote 1
Diabetes Education Programs ***(requires physician supervision)***		
• Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$20/visit[2] ***(deductible waived)***	See footnote 1

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(subject to medical necessity review administered by American Specialty Health- ASH)*	20%	See footnote 1
Speech Therapy • Outpatient speech therapy	20%	See footnote 1
Acupuncture [3] • Services for the treatment of disease, illness or injury *(limited to 12 visits/calendar year)*	20%	50% of maximum allowed amount[5]
Diagnostic X-ray & Lab • Other diagnostic x-ray & lab	20%	See footnote 1
Advanced Imaging ***(subject to utilization review)*** • MRI, CT Scan, PET Scan & nuclear cardiac exam	20%	See footnote 1 *(benefit limited to $800/procedure)*
Urgent Care ***(physician services)***	$20/visit[2] ***(deductible waived)***	See footnote 1
Emergency Care • Emergency room services & supplies *($100 co-pay waived if admitted inpatient)* [4]	20%	20% of maximum allowed amount for true emergency
• Inpatient hospital services & supplies [4]	20%	20% first 48 hours; After 48 hours: all billed amounts exceeding $600/day unless member cannot be moved safely
• Physician services [4]	20%	20% of maximum allowed amount for true emergency
Hospital Medical Services ***(subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)*** • Semi-private room, medically necessary services & supplies	20%	All billed amounts exceeding $600/day
• Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	50% of maximum allowed amount[5]
• Single Hip or Knee Joint Replacement Surgery – up to $30,000 per surgery. Travel expense when member's home is 50 miles or more from a low cost facility. ($3,000 maximum travel benefit per surgery)	20%	All billed amounts exceeding $600/day
Skilled Nursing Facility (subject to utilization review) • Semi-private room, services & supplies (limited to 100 days/calendar year)	20%	All billed amounts exceeding $600/day
Related Outpatient Medical Services & Supplies[5] • Ground or air ambulance transportation, services & disposable supplies *(air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to $50,000 for non-PPO)*	20%	20% maximum allowed amount for true emergency[5]
• Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%	20% maximum allowed amount[5]
• Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	20%	20% maximum allowed amount[5]
Ambulatory Surgical Centers ***(certain surgeries are subject to utilization review)*** • Outpatient surgery, services & supplies	20%	All billed amounts exceeding $350/day
Pregnancy & Maternity Care • Physician office visits	$20/visit[2] ***(deductible waived)***	See footnote 1
• Prescription drug for elective abortion *(mifepristone)* Normal delivery, cesarean section, complications of pregnancy & abortion. Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.	20%	See footnote 1
Mental or Nervous Disorders and Substance Abuse Inpatient Care • Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	All billed amounts exceeding $600/day
• Inpatient physician visits	20%	See footnote 1

CONTINUED ON NEXT PAGE

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay†
Outpatient Care • Facility-based care *(subject to utilization review; waived for emergency admissions)* • Outpatient physician visits	20% $20/visit[2]	50% of maximum allowed amount[5] See footnote 1
Durable Medical Equipment ***(may be subject to utilization review)*** • Rental or purchase of DME *(breast pump and supplies are covered under preventive care at no charge for in-network only)* • Hearing aid supplies and equipment (limited to $700 per 24 months)	20% 20%	See footnote 1 See footnote 1
Home Health Care ***(subject to utilization review)*** • Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	See footnote 1
Home Infusion Therapy ***(subject to utilization review)*** • Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	All billed amounts exceeding $600/day
Hemodialysis • Outpatient hemodialysis services & supplies	20%	All billed amounts exceeding $350/visit
Hospice Care • Inpatient or outpatient services; family bereavement services	No copay ***(deductible waived)***	All billed amounts exceeding the maximum allowed amount
Bariatric Surgery ***(subject to utilization review; covered only when performed at a Centers of Medical Excellence [CME])*** • Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity • Travel expenses when member's home is 50 miles or more from the nearest Bariatric CME *($3,000 maximum travel benefit per surgery)*	20% No copay ***(deductible waived)***	Not covered Not covered
Organ & Tissue Transplants ***(subject to utilization review; specified transplants covered only when performed at a Centers of Medical Excellence [CME])*** • Inpatient services provided in connection with non-investigative organ or tissue transplants • Transplant travel expense for an authorized, specified transplant *(recipient & companion transportation limited to $10,000 per transplant)* • Unrelated donor search, limited to $30,000 per transplant	20% No copay ***(deductible waived)***	Not covered Not covered
Prosthetic Devices • Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes	20%	See footnote 1

Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense. This Summary of Benefits has been updated to comply with federal requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

1 The plan pays 100% of the fee schedule. The member is responsible for all amounts exceeding the fee schedule.

2 The dollar copay applies only to the visit itself. An additional copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

3 Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

4 The allowable rate for non-PPO emergency care within 48 hours is based on a reasonable charge, not the scheduled amount.

5 These providers may not be represented in the PPO network in the state where the member receives services. Reimbursements for these non-PPO providers are based on a reasonable charge, not the scheduled amount.

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.
Excess Amounts. Any amounts in excess of covered expense or any medical benefit maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines: 1. It must be internationally known as being devoted mainly to medical research; 2. At least 10% of its yearly budget must be spent on research not directly related to patient care; 3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care; 4. It must accept patients who are unable to pay; and 5. Two-thirds of its patients must have conditions directly related to the hospital's research.
Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:
1. Extraction, restoration, and replacement of teeth; 2. Services to improve dental clinical outcomes. This exclusion does not apply to the following:
1. Services which we are required by law to cover; 2. Services specified as covered in this booklet;
3. Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.
Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the EOC.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.
Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal. Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications as specified as covered in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Private duty nursing services.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Wigs.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.
Coordination of Benefits — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

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Self-Insured Schools of California (SISC)
Pharmacy Benefit Schedule

Benefit Effective Date				
October 1, 2014				
Benefit Type				
Participating Pharmacy			Up to 30 Days	
Costco Retail			Up to 90 Days	
Costco Mail Order			Up to 90 Days	
Benefit Structure				
Level	***Costco Retail Pharmacy 30 day***	**Costco Retail Pharmacy 90 day**	***Other Retail Pharmacy 30 day***	***Costco Mail Order 90 day***
Generic	$0	$0	$9	$0
Brand	$35	$90	$35	$90
Annual Out-of-Pocket Maximum				
Individual Maximum			$6,350	
Family Maximum			$12,700	
Additional Coverage Information				

- Up to a 90 day supply of generic medications are free at Costco retail and mail order pharmacies; specialty, narcotic pain and cough medications are not included. Some narcotic pain medications and cough medications require the regular retail copay at Costco and 3 times the regular retail copay at Mail.
- Fill a 90 day supply of brand medication at Costco retail and pay the mail order copay.

- Diabetic supplies are only available as brand prescriptions and not generic. However, the SISC pharmacy plans charge the generic copay on preferred brand supplies (lancets, pen needles, test strips and syringes).
- SISC urges members to use generic drugs when they are available. If you or your physician requests the brand name when a generic equivalent is available, you will pay the generic copay plus the difference in cost between the brand and generic. The difference in cost between the brand and generic will not count toward the Annual Out-of-Pocket Maximum.

Mail Order Service

The Mail Order Service allows you to receive a 90-day supply of maintenance medications. This program is part of your pharmacy benefit and is **voluntary.**

Specialty Pharmacy

Navitus SpecialtyRx helps members who are taking medications for certain chronic illnesses or complex diseases by providing services that offer convenience and support. This program is part of your pharmacy benefit and is **mandatory**.

SISC-Self Insured Schools of California: $1000 Deductable Plan

Principal Benefits for
Kaiser Permanente Deductible HMO Plan (10/1/14—9/30/15)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments, add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	$3,000 per calendar year
For any one Member in a Family of two or more Members	$3,000 per calendar year
For an entire Family of two or more Members	$6,000 per calendar year

Deductible for Certain Services

For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach one of the following Deductible amounts:

For self-only enrollment (a Family of one Member)	$1,000 per calendar year
For any one Member in a Family of two or more Members	$1,000 per calendar year
For an entire Family of two or more Members	$2,000 per calendar year
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	You Pay
Most primary and specialty care consultations, exams, and treatment	$20 per visit (Deductible doesn't apply)
Routine physical maintenance exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling	No charge (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge (Deductible doesn't apply)
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$20 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy	$20 per visit (Deductible doesn't apply)

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Deductible
Allergy injections (including allergy serum)	No charge (Deductible doesn't apply)
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter (Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure (Deductible doesn't apply)
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Deductible

Emergency Health Coverage	You Pay
Emergency Department visits	20% Coinsurance after Deductible

Ambulance Services	You Pay
Ambulance Services	$150 per trip (Deductible doesn't apply)

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply (Deductible doesn't apply)
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply (Deductible doesn't apply)

 (continues)

Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply, $60 for a 31- to 60-day supply, or $90 for a 61- to 100-day supply (Deductible doesn't apply)
Most brand-name refills through our mail-order service	$30 for up to a 30-day supply or $60 for a 31- to 100-day supply (Deductible doesn't apply)

Durable Medical Equipment	**You Pay**
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20% Coinsurance (Deductible doesn't apply)

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	20% Coinsurance after Deductible
Individual outpatient mental health evaluation and treatment	$20 per visit (Deductible doesn't apply)
Group outpatient mental health treatment	$10 per visit (Deductible doesn't apply)

Chemical Dependency Services	**You Pay**
Inpatient detoxification	20% Coinsurance after Deductible
Individual outpatient chemical dependency evaluation and treatment	$20 per visit (Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Deductible doesn't apply)

Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge (Deductible doesn't apply)

Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance (Deductible doesn't apply)
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge (Deductible doesn't apply)
All Services related to covered infertility treatment	50% Coinsurance (Deductible doesn't apply)
Hospice care	No charge (Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Proposed Benefit Summary

SISC-Self Insured Schools of California: $20 OV, $10-20 Rx w/ OPT & Chiro

Principal Benefits for Kaiser Permanente Traditional Plan (10/1/14—9/30/15)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Deductible or Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$20 per visit
Routine physical maintenance exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	$20 per visit
Physical, occupational, and speech therapy	$20 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$20 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Health education:	
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit

Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).

Ambulance Services	**You Pay**
Ambulance Services	$50 per trip

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service:	
Most generic items	$10 for up to a 100-day supply
Most brand-name items	$20 for up to a 100-day supply

Durable Medical Equipment	**You Pay**
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$20 per visit
Group outpatient mental health treatment	$10 per visit

(continues)

Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$20 per visit
Group outpatient chemical dependency treatment	$5 per visit

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge

Other	You Pay
Eyewear purchased at Plan Medical Offices or plan optical sales offices every 24 months	Amount in excess of $150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge
All Services related to covered infertility treatment	50% Coinsurance
Hospice care	No charge
Chiropractor	$10 per visit, 30 visits per year

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).