SISC
Self-Insured Schools of California
Schools Helping Schools

Health Benefits Proposal

for

Glendale Community College District

April 28, 2021

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A Joint Powers Agreement Administered by the Kern County Superintendent of Schools Office
Mary C. Barlow, Superintendent

SISC
Self-Insured Schools of California
Schools Helping Schools

Take advantage of no cost benefits to help you get and stay healthy

BENEFIT HIGHLIGHTS	AVAILABILITY AND HOW TO GET STARTED
24/7 Help with Personal Concerns *SISC Employee Assistance Program* Access free, confidential resources for help with emotional, marital, financial, addiction, legal, or stress issues.	All employees at member districts **Call** 800-999-7222 **Visit** anthemEAP.com and enter SISC
Expert Medical Opinions *Teladoc Medical Experts* Get answers to health care questions and second opinions from world-leading experts.	All members enrolled in a SISC medical plan **Call** 800-835-2362 **Visit** teladoc.com/SISC
24/7 Physician Access—Anytime, Anywhere *MDLive* Consult with doctors and pediatricians over the phone or using online video for common medical conditions and behavioral health issues. Physicians can prescribe medication when appropriate.	Anthem and Blue Shield members **Call** 888-632-2738 **Visit** mdlive.com/sisc
Free Generic Medications *Costco* Access most generic medications at no cost through Costco retail and mail oder pharmacies. You don't need to be a Costco member.	Anthem and Blue Shield members **Call** 800-774-2678 (press 1) **Visit** costco.com
Enhanced Cancer Benefit *Contigo Health* Consult experts on initial diagnosis and development of a care plan. Benefit includes care coordination services with at home provider, transportation, and more.	Anthem and Blue Shield PPO members **Call** 877-220-3556 **Visit** sisc.contigohealth.com

Per IRS guidelines, HSA members may need to satisfy a deductible when using these programs.

Continued →

BENEFIT HIGHLIGHTS

AVAILABILITY AND HOW TO GET STARTED

Hip, Knee, and Spine Surgical Benefit *Carrum Health* Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills.	Anthem and Blue Shield PPO members **Call** 888-855-7806 **Visit** carrumhealth.com/sisc
Personal Health Coaching *Vida Health* Get one-on-one health coaching, therapy, chronic condition management, health trackers and other tools and resources online or via phone.	Anthem and Blue Shield members **Call** 855-442-5885 **Visit** vida.com/sisc
Physical Therapy for Back or Joint Pain *Hinge Health* Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy.	Anthem and Blue Shield PPO members **Call** 855-902-2777 **Visit** hingehealth.com/sisc

Per IRS guidelines, HSA members may need to satisfy a deductible when using these programs.

blue of california

Self-Insured Schools of California
Effective October 1, 2020
PPO Plan

Summary of Benefits

90% Plan G $20 Copayment

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.[1] Please read both documents carefully for details.

Medical Provider Network: Full PPO Network

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Claims Administrator pays for Covered Services under the Plan. The Claims Administrator pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$500
	Family coverage	$500: individual
		$1,000: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$1,000
Family coverage	$1,000: individual
	$3,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services.

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		Not covered	
Physician services[10]				
Primary care office visit	$20/visit		50%	✔
Specialist care office visit	$20/visit		50%	✔
Physician home visit	$20/visit		50%	✔
Physician or surgeon services in an outpatient facility	10%	✔	50%	✔
Physician or surgeon services in an inpatient facility	10%	✔	50%	✔
Other professional services[10]				
Other practitioner office visit	$20/visit		50%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	10%	✔	50%	✔
Up to 12 visits per Member, per Calendar Year.				
Chiropractic services	10%	✔	Not covered	
Up to 20 visits per Member, per Calendar Year.				
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive	$0		Not covered	
• Diaphragm fitting	$0		Not covered	
• Intrauterine device (IUD)	$0		Not covered	
• Insertion and/or removal of intrauterine device (IUD)	$0		Not covered	
• Implantable contraceptive	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	10%	✔	Not covered	
• Diagnosis and Treatment of the Cause of Infertility	Not covered		Not covered	
Podiatric services	$20/visit		50%	✔
Pregnancy and maternity care[7, 10]				
Physician office visits: prenatal and postnatal	$20/visit		50%	✔
Physician services for pregnancy termination	10%	✔	Not covered	
Certified nurse midwives	10%	✔	10%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Emergency services				
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	$100/visit plus 10%	✔	$100/visit plus 10%	✔
Emergency room Physician services	10%	✔	10%	✔
Urgent care center services[10]	$20/visit		50%	✔
Ambulance services *This payment is for emergency or authorized transport.*	$100/transport plus 10%	✔	$100/transport plus 10%	✔
Outpatient facility services				
Ambulatory Surgery Center	10%	✔	All charges above $350	✔
Outpatient Department of a Hospital: surgery	10%	✔	All charges above $350	✔
Arthroscopy[8]	10% of up to $4,500/procedure plus 100% of additional charges	✔	Not covered	
Cataract Surgery[8]	10% of up to $2,000/procedure plus 100% of additional charges	✔	Not covered	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	✔	50% of up to $350/day plus 100% of additional charges	✔
Inpatient facility services				
Hospital services and stay	10%	✔	All charges above $600	✔
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.* • Special transplant facility inpatient services	10%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Physician inpatient services	10%	✔	Not covered	
Transplant Travel Benefit: Maximum payment will not exceed $10,000 per transplant, (not per lifetime) Ground transportation to and from the Center of Excellence (COE) when the desig-nated COE is 75 miles or more from the recipi-ent's or donor's place of residence. Coach air-fare to and from the COE when the designated COE is 300 miles or more from the recipient's or donor's residence.	All charges above $10,000/ transplant		Not covered	
Bariatric surgery services, designated California counties				
This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the outpatient facility services and Outpatient Physician services payments apply.				
Inpatient facility services	10%	✔	Not covered	
Outpatient facility services	10%	✔	Not covered	
Physician services	10%	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	10%	✔	Not covered	
• Outpatient Department of a Hospital	10%	✔	Not covered	
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	10%	✔	Not covered	
• Outpatient Department of a Hospital	10%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Other outpatient diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	10%	✔	Not covered	
• Outpatient Department of a Hospital	10%	✔	Not covered	
Radiological and nuclear imaging services				
• Outpatient radiology center	10%	✔	50%	✔
• Outpatient Department of a Hospital	10%	✔	50% of up to $350/day plus 100% of additional charges	✔
Colonoscopy[8]	10% of up to $1,500/procedure plus 100% of additional charges	✔	Not covered	
Upper GI Endoscopy[8]	10% of up to $1,000/procedure plus 100% of additional charges	✔	Not covered	
Upper GI Endoscopy with Biopsy[8]	10% of up to $1,250/procedure plus 100% of additional charges	✔	Not covered	
Rehabilitative and Habilitative Services				
Includes Physical Therapy, Occupational Therapy, and Respiratory Therapy.				
Office location	10%	✔	Not covered	
Outpatient Department of a Hospital	10%	✔	Not covered	
Speech Therapy services				
Office location	10%	✔	50%	✔
Outpatient Department of a Hospital	10%	✔	50%	✔
Durable medical equipment (DME)				
DME	10%	✔	Not covered	
Breast pump	$0		Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Orthotic equipment and devices *Up to 2 pairs of shoes and 2 inserts for therapeutic shoes per Calendar Year. Additional 2 pair of orthotics allowed post-surgery*	10%	✔	Not covered	
Prosthetic equipment and devices	10%	✔	50%	✔
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	10%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs and medical supplies.*	10%	✔	Not covered	
Home visits by an infusion nurse	10%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	10%	✔	Not covered	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*				
Freestanding SNF	10%	✔	10%	✔
Hospital-based SNF	10%	✔	All charges above $600	✔
Hospice program services				
Pre-Hospice consultation	$0		Not covered	
Routine home care	$0		Not covered	
24-hour continuous home care	$0		Not covered	
Short-term inpatient care for pain and symptom management	$0		Not covered	
Inpatient respite care	$0		Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Other services and supplies[10]				
Diabetes care services				
• Devices, equipment, and supplies	10%	✔	50%	✔
• Self-management training	$20/visit		50%	✔
Dialysis services	10%	✔	50% of up to $350/day plus 100% of additional charges	✔
PKU product formulas and Special Food Products	10%	✔	Not covered	
Allergy serum billed separately from an office visit	10%	✔	50%	✔
Hearing services				
• Hearing aids and equipment *Up to $700 combined maximum per Member, per 24 months.*	10%	✔	10%	✔
• Audiological evaluations	$20/visit		50%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
	When using a Participating Provider or MHSA Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider or MHSA Non-Participating Provider[4, 9]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$20/visit		50%	✔
Intensive outpatient care	10%	✔	50%	✔
Behavioral Health Treatment in an office setting	10%	✔	50%	✔
Behavioral Health Treatment in home or other non-institutional setting	10%	✔	50%	✔
Office-based opioid treatment	10%	✔	50%	✔
Partial Hospitalization Program	10%	✔	50% of up to $350/day plus 100% of additional charges	✔
Psychological Testing	10%	✔	50%	✔
Inpatient services				
Physician inpatient services	10%	✔	50%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
	When using a Participating Provider or MHSA Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider or MHSA Non-Participating Provider[4, 9]	CYD[2] applies
Hospital services	10%	✔	All charges above $600	✔
Residential Care	10%	✔	All charges above $600	✔

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits
- Inpatient facility services
- Hospice program services

Please review the Benefit Booklet for more about Benefits that require prior authorization.

Notes

1 Benefit Booklet:

The Benefit Booklet describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

Capitalized terms are defined in the Benefit Booklet. Refer to the Benefit Booklet for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before the Claims Administrator pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by the Claims Administrator before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

This benefit Plan has a combined Participating Provider and Non-Participating Provider Calendar Year Deductible.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

Notes

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Any charges above the specified Benefit maximum are not covered, do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount, or
- any charges above the stated dollar amount, which is the Benefit maximum.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Charges above the Allowable Amount or Benefit maximum do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.
- Some Benefits from Non-Participating Providers have the Allowable Amount or Benefit maximum listed in the Benefits chart as a specific dollar ($) amount. You are responsible for any charges above the Allowable Amount or Benefit maximum, whether or not an amount is listed in the Benefits chart.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This benefit Plan has a combined Participating Provider and Non-Participating Provider OOPM. However, only the following Non-Participating Provider services will accrue to the combined OOPM:

- Ambulance services;
- Emergency services;
- Certified Nurse Midwives;
- Skilled nursing facilities (SNF) services at a Freestanding SNF; and
- Hearing aids and equipment.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example,

Notes

you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

8 Outpatient Facility Services

Services and supplies for the following Outpatient surgeries are subject to a Benefit maximum if performed in the Outpatient department of a Hospital: athroscopy, cataract surgery, colonoscopy, upper GI endoscopy, and upper GI endoscopy with biopsy. The Benefit maximum does not apply when the same services are provided in a participating Ambulatory Surgery Center.

9 For Services by Non-Preferred, Non-Participating and MHSA Non-Participating Providers:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

You are responsible for all charges above the Allowable Amount. However, if the Non-Preferred/Non-Participating/MHSA Non-Participating Provider is a Hospital based Physician performing Services at a Participating/MHSA Participating Provider (in-network) facility; or out of network lab services, when performed by an in-network (participating) provider, but sent to a non-participating provider for processing, the Claims Administrator's payment will be made at the Participating Provider copayment level.

Authorized Referrals for Services by Non-Preferred/Non-Participating//MHSA Non-Participating Providers –

In some circumstances, the Claims Administrator may authorize participating provider cost share amounts (Deductibles or Co-Payments, if applicable) to apply to a claim for a covered service you receive from a non-participating provider. In such circumstance, you or your physician must contact the Claims Administrator in advance of obtaining the covered service. It is your responsibility to ensure that the Claims Administrator has been contacted. If the Claims Administrator authorizes a participating provider cost share amount to apply to a covered service received from a non-participating provider, you also may still be liable for the difference between the maximum allowed amount and the non-participating provider's charge. Please call the customer service telephone number on the back of your ID card for authorized referral information or to request authorization.

Authorized referral occurs when you, because of your medical needs, are referred to a non-participating provider, but only when:

a. There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence;
b. You are referred in writing to the non-participating provider by the physician who is a participating provider, and
c. The referral has been authorized by the Claims Administrator before services are rendered. You or your physi-cian must call the toll-free telephone number printed on the back of your identification card prior to scheduling an admission to, or receiving the services of, a non-participating provider. Such authorized referrals are not available for transplant and bariatric surgical services. These services are only covered when performed at a COE.

10 First Dollar Coverage:

This Plan offers first dollar coverage for 3 office visits with Participating Providers. This means the Claims Administrator will pay for these Covered Services before you are charged a Copayment.

First dollar coverage is available for office visits with a Participating Physician, for any combination of these Provider types:

- General practice
- Family practice
- Internal Medicine
- Pediatrics
- Nurse Practitioner
- Physician's Assistant
- Obstetrics
- Gynecology

After you reach the 3 office visit maximum under the first dollar coverage benefit, additional office visits in the same Calendar Year are subject to the applicable Participating Provider office visit Copayment.

Non-Participating Provider office visits are not covered under the first dollar coverage. These services are covered as described in the Benefits chart above.

Plans may be modified to ensure compliance with Federal requirements.

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SISC
Self-Insured Schools of California
Schools Helping Schools

NAVITUS HEALTH SOLUTIONS

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

PLAN RX 3-15

	Walk-In				Mail	
	Network		Costco		Costco	Navitus
Days' Supply*	30	90	30	90	90	30
Generic	$3	N/A	**FREE**	**FREE**	**FREE**	N/A
Brand	$15	N/A	$15	$35	$35	N/A
Specialty	N/A	N/A	N/A	N/A	N/A	$15

Out-of-Pocket Maximum	$1,500 Individual / $2,500 Family

SISC urges members to use generic drugs when 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.

*Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies. Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs. Navitus contracts with most independent and chain pharmacies with the exception of Walgreens.

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**.

For information regarding the Prescription Drug Program call or visit on-line:
Navitus Customer Care 1-866-333-2757 (toll-free) TTY (toll free) 711 www.navitus.com

Navi-Gate® for Members allows you to access personalized pharmacy benefit information online at **www.navitus.com.** For information specific to your plan, visit Navi-Gate® for Members. Activate your account online using the Member Login link and an activation email will be sent to you. The site provides access to prescription benefits, pharmacy locator, drug search, drug interaction information, medication history, and mail order information. The site is available 24 hours a day, seven days a week.

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Self-Insured Schools of California
Effective October 1, 2020
HMO Plan

Summary of Benefits

Custom HMO 10 Zero Admit

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: Access+ HMO Network

This Plan uses a specific network of Health Care Providers, called the Access+ HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual
		$0: Family

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

	When using a Participating Provider[3]
Individual coverage	$1,000
Family coverage	$1,000: individual
	$2,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

Benefits[5]	Your payment: When using a Participating Provider[3]	Your payment: CYD[2] applies
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$10/visit	
Access+ specialist care office visit (self-referral)	$30/visit	
Other specialist care office visit (referred by PCP)	$10/visit	
Physician home visit	$10/visit	
Physician or surgeon services in an outpatient facility	$0	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit	$10/visit	
Includes nurse practitioners, physician assistants, and therapists.		
Family planning		
• Counseling, consulting, and education	$0	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$0	
Podiatric services	$10/visit	
Pregnancy and maternity care[6]		
Physician office visits: prenatal and postnatal	$0	
Physician services for pregnancy termination	$0	
Emergency services		
Emergency room services	$100/visit	
If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.		
Emergency room Physician services	$0	

Benefits[5]	Your payment: When using a Participating Provider[3]	Your payment: CYD[2] applies
Urgent care center services	$10/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$100/transport	
Outpatient facility services		
Ambulatory Surgery Center	$0	
Outpatient Department of a Hospital: surgery	$0	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	
Inpatient facility services		
Hospital services and stay	$0	
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*		
• Special transplant facility inpatient services	$0	
• Physician inpatient services	$0	
Diagnostic x-ray, imaging, pathology, and laboratory services *This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.*		
Laboratory services *Includes diagnostic Papanicolaou (Pap) test.*		
• Laboratory center	$0	
• Outpatient Department of a Hospital	$0	
X-ray and imaging services *Includes diagnostic mammography.*		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Other outpatient diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*		
• Office location	$0	
• Outpatient Department of a Hospital	$0	

Benefits[5]	Your payment: When using a Participating Provider[3]	Your payment: CYD[2] applies
Radiological and nuclear imaging services		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Rehabilitative and Habilitative Services		
Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.		
Office location	$10/visit	
Outpatient Department of a Hospital	$10/visit	
Durable medical equipment (DME)		
DME	$0	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health care services	$10/visit	
Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.		
Home infusion and home injectable therapy services		
Home infusion agency services	$0	
Includes home infusion drugs and medical supplies.		
Home visits by an infusion nurse	$10/visit	
Hemophilia home infusion services	$0	
Includes blood factor products.		
Skilled Nursing Facility (SNF) services		
Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.		
Freestanding SNF	$0	
Hospital-based SNF	$0	
Hospice program services	$0	
Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.		

Benefits[5]	Your payment: When using a Participating Provider[3]	Your payment: CYD[2] applies
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	$0	
• Self-management training	$10/visit	
Dialysis services	$0	
PKU product formulas and Special Food Products	$0	
Allergy serum billed separately from an office visit	50%	
Hearing services		
• Hearing aids and equipment	50%	
1 hearing aid per member, per 24 months.		

Mental Health and Substance Use Disorder Benefits *Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).*	Your payment: When using a MHSA Participating Provider[3]	Your payment: CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$10/visit	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0	
Partial Hospitalization Program	$0	
Psychological Testing	$0	
Inpatient services		
Physician inpatient services	$0	
Hospital services	$0	
Residential Care	$0	

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

Notes

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

5 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Plans may be modified to ensure compliance with State and Federal requirements.
LG032520

blue of california

Acupuncture and Chiropractic Services Rider

Group Rider
HMO/POS

Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this acupuncture and chiropractic services Benefit.

Benefits	Your Payment	
Covered Services must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans). *Up to 30 visits per Member, per Calendar Year. The 30 visit maximum is for acupuncture and chiropractic services combined.* *Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.*	**When using an ASH Participating Provider**	**When using a Non-Participating Provider**
Acupuncture Services		
Office visit	$10/visit	Not covered
Chiropractic Services		
Office visit	$10/visit	Not covered
Chiropractic Appliances	All charges above $50	Not covered

Benefit Plans may be modified to ensure compliance with State and Federal Requirements.

Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for acupuncture and chiropractic services as described in this supplement. The Benefits covered under this rider must be received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. These acupuncture and chiropractic Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply. A referral from your Primary Care Physician is not required.

All Covered Services, except for (1) the initial examination and treatment by an ASH Participating Provider; and (2) Emergency Services, must be determined as Medically Necessary by ASH Plans.

Note: ASH Plans will respond to all requests for Medical Necessity review within five business days from receipt of the request.

Covered Services received from providers who are not ASH Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no ASH Participating Providers. If ASH Plans determines Covered Services from a provider other than a Participating Provider are Medically Necessary, you will be responsible for the Participating Provider Copayment amount.

Benefits

Acupuncture Services

Benefits are available for Medically Necessary acupuncture services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, subsequent office visits and the treatment of:

headaches (tension-type and migraines);
hip or knee joint pain associated with osteoarthritis (OA);
other extremity joint pain associated with OA or mechanical irritation;
other pain syndromes involving the joints and associated soft tissues;
back and neck pain; and
nausea associated with pregnancy, surgery, or chemotherapy.

Chiropractic Services

Benefits are available for Medically Necessary chiropractic services for the treatment of Musculoskeletal and Related Disorders, nausea and pain.

Benefits include an initial examination, subsequent office visits and the following services:

spinal and extra-spinal joint manipulation (adjustments);
adjunctive therapy such as electrical muscle stimulation or therapeutic exercises;
plain film x-ray services; and
chiropractic supports and appliances.

Visits for acupuncture and chiropractic services are limited to a per Member per Calendar Year maximum as shown on the Summary of Benefits. Benefits must be provided in an office setting. You will be referred to your Primary Care Physician for evaluation of conditions not related to a Musculoskeletal and Related Disorder and for other services not covered under this rider such as diagnostic imaging (e.g. CAT scans or MRIs).

Note: You should exhaust the Benefits covered under this rider before accessing the same services through the "Alternative Care Discount Program," which is a wellness discount program. For more information about the Alternative Care Discount Program, visit www.blueshieldca.com.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Exclusions

Acupuncture services do not include:

treatment of asthma;
treatment of addiction (including without limitation smoking cessation); or
vitamins, minerals, nutritional supplements (including herbal supplements), or other similar products.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Member Services

For all acupuncture and chiropractic services, Blue Shield of California has contracted with ASH Plans to act as the Plan's acupuncture and chiropractic services administrator. Contact ASH Plans with questions about acupuncture and chiropractic services, ASH Participating Providers, or acupuncture and chiropractic Benefits.

Contact ASH Plans at:

1-800-678-9133
American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

Definitions

American Specialty Health Plans of California, Inc. (ASH Plans)	ASH Plans is a licensed, specialized health care service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of acupuncture and chiropractic services.
ASH Participating Provider	An acupuncturist or a chiropractor under contract with ASH Plans to provide Covered Services to Members.
Musculoskeletal and Related Disorders	Musculoskeletal and Related Disorders are conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders and subluxation.

Please be sure to retain this document. It is not a contract but is a part of your EOC.

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Notice of the Availability of Language Assistance Services
Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíníghah? Doo bíníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់ៈ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอคงามช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

SISC
Self-Insured Schools of California
Schools Helping Schools

NAVITUS HEALTH SOLUTIONS

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

PLAN RX 5-20

	Walk-In				Mail	
	Network		Costco		Costco	Navitus
Days' Supply*	30	90	30	90	90	30
Generic	$5	N/A	**FREE**	**FREE**	**FREE**	N/A
Brand	$20	N/A	$20	$50	$50	N/A
Specialty	N/A	N/A	N/A	N/A	N/A	$20

Out-of-Pocket Maximum	$1,500 Individual / $2,500 Family

SISC urges members to use generic drugs when 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.

*Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies. Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs. Navitus contracts with most independent and chain pharmacies with the exception of Walgreens.

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**.

For information regarding the Prescription Drug Program call or visit on-line:
Navitus Customer Care 1-866-333-2757 (toll-free) TTY (toll free) 711 www.navitus.com

Navi-Gate® for Members allows you to access personalized pharmacy benefit information online at **www.navitus.com.** For information specific to your plan, visit Navi-Gate® for Members. Activate your account online using the Member Login link and an activation email will be sent to you. The site provides access to prescription benefits, pharmacy locator, drug search, drug interaction information, medication history, and mail order information. The site is available 24 hours a day, seven days a week.

Disclosure Form

SISC - Self-Insured Schools of California

Principal benefits for Kaiser Permanente Traditional HMO Plan

(10/1/20—9/30/21)

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$10 per visit
Most Physician Specialist Visits	$10 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$10 per visit
Most physical, occupational, and speech therapy	$10 per visit

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	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 Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	You Pay
Ambulance Services	$50 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most specialty items at a Plan Pharmacy	$10 for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	No charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$10 per visit
Group outpatient substance use disorder treatment	$5 per visit

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

Other	You Pay
Hearing aid(s) every 36 months	Amount in excess of $500 Allowance per aid

(continues)

Disclosure Form *(continued)*

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	the Cost Share you would pay if the Services were to treat any other condition
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge

Chiropractic and Acupuncture Coverage (through ASH Plans)	You Pay
Up to a combined total of 30 Chiropractic and Acupuncture visits per year	$10 copay per visit

Kaiser Permanente contracts with American Specialty Health Plans (ASH) to provide chiropractic and acupuncture care. Members must receive all their benefits from ASH Plans participating providers. ASH Plans contracts with Participating Providers and other licensed providers to provide covered Chiropractic Services (including laboratory tests, X-rays, and chiropractic appliances). ASH Plans contracts with Participating Providers to provide acupuncture care (including adjunctive therapies, such as acupressure, moxibustion, or breathing techniques, when provided during the same course of treatment and in conjunction with acupuncture). You must receive covered Services from a Participating Provider or another licensed provider with which ASH contracts, except for Emergency Chiropractic Services, Emergency Acupuncture Services, Urgent Chiropractic Services, and Urgent Acupuncture Services, and Services that are not available from Participating Providers or other licensed providers with which ASH contracts to provide covered Services that are authorized in advance by ASH Plans.

The list of Participating Providers is available on the ASH Plans website at **www.ashlink.com/ash/kp** or from the ASH Plans Customer Service Department at **1-800-678-9133**. The list of Participating Providers is subject to change at any time without notice.

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

Disclosure Form

SISC - Self-Insured Schools of California

Principal benefits for Kaiser Permanente Deductible HMO Plan

(10/1/20—9/30/21)

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$3,000	$3,000	$6,000
Plan Deductible	$500	$500	$1,000
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$20 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$20 per visit (Plan Deductible doesn't apply)

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	10% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	No charge (Plan Deductible doesn't apply)
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter (Plan Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	10% Coinsurance up to a maximum of $50 per procedure (Plan Deductible doesn't apply)

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	10% Coinsurance after Plan Deductible

Emergency Health Coverage	**You Pay**
Emergency Department visits	10% Coinsurance after Plan Deductible

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

Ambulance Services	**You Pay**
Ambulance Services	$150 per trip (Plan 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 (Plan Deductible doesn't apply)
Most generic refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)

Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance (Plan Deductible doesn't apply)

(continues)

Disclosure Form *(continued)*

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

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	10% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	$5 per visit (Plan Deductible doesn't apply)

Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)

Other	You Pay
Hearing aid(s) every 36 months	Amount in excess of $500 Allowance per aid (Allowance not subject to Plan Deductible)
Skilled nursing facility care (up to 100 days per benefit period)	10% Coinsurance (Plan Deductible doesn't apply)
Prosthetic and orthotic devices as described in the *EOC*	No charge (Plan Deductible doesn't apply)
Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	the Cost Share you would pay if the Services were to treat any other condition
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge (Plan Deductible doesn't apply)

Chiropractic and Acupuncture Coverage (through ASH Plans)	You Pay
Up to a combined total of 30 Chiropractic and Acupuncture visits per year	$10 copay per visit

Kaiser Permanente contracts with American Specialty Health Plans (ASH) to provide chiropractic and acupuncture care. Members must receive all their benefits from ASH Plans participating providers. ASH Plans contracts with Participating Providers and other licensed providers to provide covered Chiropractic Services (including laboratory tests, X-rays, and chiropractic appliances). ASH Plans contracts with Participating Providers to provide acupuncture care (including adjunctive therapies, such as acupressure, moxibustion, or breathing techniques, when provided during the same course of treatment and in conjunction with acupuncture). You must receive covered Services from a Participating Provider or another licensed provider with which ASH contracts, except for Emergency Chiropractic Services, Emergency Acupuncture Services, Urgent Chiropractic Services, and Urgent Acupuncture Services, and Services that are not available from Participating Providers or other licensed providers with which ASH contracts to provide covered Services that are authorized in advance by ASH Plans.

The list of Participating Providers is available on the ASH Plans website at **www.ashlink.com/ash/kp** or from the ASH Plans Customer Service Department at **1-800-678-9133**. The list of Participating Providers is subject to change at any time without notice.

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

Provided by American Specialty Health Plans of California, Inc. (ASH Plans)

Your Kaiser Permanente **CHIROPRACTIC and ACUPUNCTURE benefits**

When you need chiropractic or acupuncture care, follow these simple steps:

1. Find an ASH Plans Participating Provider near you:
   - Go to **ashlink.com/ash/kp**, or
   - Call **1-800-678-9133** (TTY **711**), Monday through Friday, from 5 a.m. to 6 p.m. Pacific time.
2. Schedule an appointment.
3. Pay for your office visit when you arrive for your appointment.

(See the reverse for more details.)

American Specialty Health Plans of California

KAISER PERMANENTE®

Services	Cost Sharing and Office Visit Maximums
Chiropractic Services are covered when provided by a Participating Provider and Medically Necessary to treat or diagnose Neuromusculoskeletal Disorders. Acupuncture Services are covered when a Participating Provider finds that the Services are Medically Necessary to treat or diagnose Neuromusculoskeletal Disorders, nausea, or pain. You can obtain Services from any ASH Plans Participating Providers without a referral from a Kaiser Permanente Plan Physician.	**Office visit cost share:** $10 copay per visit **Office visit limit:** Up to a combined total of 30 medically necessary Chiropractic and Acupuncture visits per year **Chiropractic appliance benefit:** If the amount of the appliance in the ASH Plans fee schedule exceeds $50, you will pay the amount in excess of $50, and that payment will not apply toward the Plan Deductible or Plan Out-of-Pocket Maximum. Covered chiropractic appliances are limited to: elbow supports, back supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units, ankles braces, knee braces, rib supports, and wrist braces.

Office visits: Covered Services are limited to Medically Necessary Chiropractic and Acupuncture Services authorized and provided by ASH Plans Participating Providers except for the initial examination, emergency and urgent Chiropractic and Acupuncture Services, and Services that are not available from Participating Providers or other licensed providers with which ASH contracts to provide covered care. Each office visit counts toward any visit limit, if applicable, even if acupuncture or a chiropractic adjustment is not provided during the visit.

X-rays and laboratory tests: Medically Necessary X-rays and laboratory tests are covered at no charge when prescribed as part of covered chiropractic care and a Participating Provider provides the Services or refers you to another licensed provider with which ASH contracts for the Services.

Participating Providers

ASH Plans contracts with Participating Providers and other licensed providers to provide covered Chiropractic Services (including laboratory tests, X-rays, and chiropractic appliances). ASH Plans contracts with Participating Providers to provide acupuncture care (including adjunctive therapies, such as acupressure, moxibustion, or breathing techniques, when provided during the same course of treatment and in conjunction with acupuncture). You must receive covered Services from a Participating Provider or another licensed provider with which ASH contracts, except for Emergency Chiropractic Services, Emergency Acupuncture Services, Urgent Chiropractic Services, and Urgent Acupuncture Services, and Services that are not available from Participating Providers or other licensed providers with which ASH contracts to provide covered Services that are authorized in advance by ASH Plans. The list of Participating Providers is available on the ASH Plans website at ashlink.com/ash/kp or from the ASH Plans Customer Service Department at **1-800-678-9133.** The list of Participating Providers is subject to change at any time without notice.

How to Obtain Covered Services

To obtain covered Services, call a Participating Provider to schedule an initial examination. If additional Services are required, verification that the Services are Medically Necessary may be required. Your Participating Provider will request any medical necessity determinations. An ASH Plan's clinician in the same or similar specialty as the provider of Services under review will decide whether Services are or were Medically Necessary. ASH Plans will disclose to you, upon request, the written criteria it uses to make the decision to authorize, modify, delay, or deny a request for authorization. If you have questions or concerns, please contact the ASH Plans Customer Service Department.

Second Opinions

You may request a second opinion in regard to covered Services by contacting another Participating Provider. A Participating Provider may also request a second opinion in regard to covered Services by referring you to another Participating Provider in the same or similar specialty.

Your Costs

When you receive covered Services, you must pay your Cost Share as described in the *Combined Chiropractic and Acupuncture Services Amendment* of your Health Plan *Evidence of Coverage*. The Cost Share does not apply toward the Plan Out-of-Pocket Maximum described in the Health Plan *Evidence of Coverage* (unless you have a plan with an HSA option).

Emergency and Urgent Chiropractic and Acupuncture Services

We cover Emergency Chiropractic Services, Emergency Acupuncture Services, Urgent Chiropractic Services, and Urgent Acupuncture Services provided by both Participating Providers and Non–Participating Providers. We do not cover follow-up or continuing care from a Non–Participating Provider unless ASH Plans has authorized the services in advance. Also, we do not cover services from a Non–Participating Provider that ASH Plans determines are not Emergency Chiropractic Services, Emergency Acupuncture Services, Urgent Chiropractic Services, or Urgent Acupuncture Services.

Getting Assistance

If you have questions about the Services you can get from an ASH Plans Participating Provider or another licensed provider with which ASH contracts, you may call ASH Plans Customer Service Department at **1-800-678-9133** (TTY users call **711**), weekdays from 5 a.m. to 6 p.m. Pacific time.

Grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with Services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in your Health Plan *Evidence of Coverage.*

Exclusions and Limitations

- Acupuncture Services for conditions other than Neuromusculoskeletal Disorders, nausea, and pain
- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational Services
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other types of diagnostic imaging or radiology other than X-rays covered under the "Covered Services" section of your *Combined Chiropractic and Acupuncture Services Amendment*
- Ambulance and other transportation
- Education programs, nonmedical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Acupuncture performed with reusable needles
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered in your *Combined Chiropractic and Acupuncture Services Amendment*
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California, except for Emergency Chiropractic Services, Emergency Acupuncture Services, Urgent Chiropractic Services, or Urgent Acupuncture Services
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- For Chiropractic Services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- For Acupuncture Services, adjunctive therapies unless provided during the same course of treatment and in conjunction with acupuncture
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- Services provided by an acupuncturist that are not within the scope of licensure for an acupuncturist licensed in California
- Maintenance care (services provided to Members whose treatment records indicate that they have reached maximum therapeutic benefit)

Definitions

Acupuncture Services: The stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions (including adjunctive therapies, such as acupressure, cupping, moxibustion, or breathing techniques, when provided during the same course of treatment and in conjunction with acupuncture) when provided by an acupuncturist for the treatment of your Neuromusculoskeletal Disorder, nausea (such as nausea related to chemotherapy, postsurgical pain, or pregnancy), or pain (such as lower back pain, shoulder pain, joint pain, or headaches).

ASH Plans: American Specialty Health Plans of California, Inc., a California corporation.

Chiropractic Services: Services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic appliances) for the treatment of your Neuromusculoskeletal Disorder.

Emergency Acupuncture Services: Covered Acupuncture Services provided for the treatment of a Neuromusculoskeletal Disorder, nausea, or pain, which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person could expect the absence of immediate Acupuncture Services to result in serious jeopardy to your health or body functions or organs.

Emergency Chiropractic Services: Covered Chiropractic Services provided for the treatment of a Neuromusculoskeletal Disorder which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person could expect the absence of immediate Chiropractic Services to result in serious jeopardy to your health or body functions or organs.

Neuromusculoskeletal Disorders: Conditions with associated signs and symptoms related to the nervous, muscular, or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders, or biomechanical dysfunction of the joints of the body or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related neurological manifestations or conditions.

Participating Provider: An acupuncturist who is licensed to provide acupuncture services in California and who has a contract with ASH Plans to provide Medically Necessary Acupuncture Services to you, or a chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you.

(continues)

Definitions *(continued)*

Urgent Acupuncture Services: Acupuncture Services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy.
- They cannot be delayed until you return to the Service Area.

Urgent Chiropractic Services: Chiropractic Services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy.
- They cannot be delayed until you return to the Service Area.

This is a summary and is intended to highlight only the most frequently asked questions about the chiropractic and acupuncture benefit, including cost shares. Please refer to the *Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for a detailed description of the chiropractic and acupuncture benefits, including exclusions and limitations, Emergency Chiropractic Services, Emergency Acupuncture Services, Urgent Chiropractic Services, or Urgent Acupuncture Services.

Kaiser Foundation Health Plan, Inc. (Health Plan) contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to make the ASH Plans network of Participating Providers available to you. You can obtain covered Services from any Participating Provider without a referral from a Plan Physician. Your Cost Share is due when you receive covered Services. Please see the definitions section of your *Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for terms you should know.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-678-9133 (TTY: 1-877-257-2746).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-678-9133 (رقم هاتف الصم والبكم: 1-877-257-2746).

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-678-9133 (TTY (հեռատիպ)՝ 1-877-257-2746):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-678-9133 (TTY: 1-877-257-2746) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-678-9133 (TTY: 1-877-257-2746) पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-678-9133 (TTY: 1-877-257-2746).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-678-9133（TTY:1-877-257-2746）まで、お電話にてご連絡ください。

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា មានផ្តល់ជូនអ្នកដោយឥតគិតថ្លៃ ។ ទូរស័ព្ទ 1-800-678-9133 (TTY: 1-877-257-2746)។

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-678-9133 (TTY: 1-877-257-2746)번으로 전화해 주십시오.

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-800-678-9133 (TTY: 1-877-257-2746).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-678-9133 (TTY: 1-877-257-2746) 'ਤੇ ਕਾਲ ਕਰੋ।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-678-9133 (телетайп: 1-877-257-2746).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-678-9133 (TTY: 1-877-257-2746).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-678-9133 (TTY: 1-877-257-2746).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-678-9133 (TTY: 1-877-257-2746)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-678-9133（TTY：1-877-257-2746）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-678-9133 (TTY: 1-877-257-2746).

SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

For our SISC Members

HEARING AID COVERAGE

Starting October 1, 2018, SISC members (actives and retires) enrolled in Kaiser Permanente (KP) will now receive hearing benefits in the amount of $500 Allowance per aid for every 36 months. *

Southern California (SCAL) KP Members	Hearing services for SCAL KP members are provided together with Kaiser Permanente Audiology Department. HEARx West, which is a joint venture between Kaiser Permanente and HearUSA. HearUSA works with your health plan to provide a broad range of affordable hearing care products and services in SCAL. HEARX West phone number is **1-800-700-3277**, Monday through Friday from 5 a.m. to 5 p.m.
Northern California (NCAL) KP Members	Hearing aids for NCAL KP members are provided at 18 Kaiser Permanente Hearing Centers in NCAL. Each center offers professional hearing aid services, products and accessories. Please call KP Member Services at **1-800-464-4000**, Monday through Friday from 8:00 a.m. to 5:00 p.m.

*A **$500 Allowance** for each ear toward the purchase price of a hearing aid every 36 months when prescribed by a Plan Physician or by a Plan Provider who is an audiologist. KP will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. KP will not provide the Allowance if KP has provided an Allowance toward (or otherwise covered) a hearing aid within the previous 36 months. Also, the Allowance can only be used at the initial point of sale. If you do not use all of your Allowance at the initial point of sale, you cannot use it later.

HEARx WEST CENTERS

If you can't find a HEARx West location near you, you may be able to use one of the Hearing Care Network locations in your area. For more information, call HEARx West toll free at **1-800-700-3277,** Monday through Friday, 5 a.m. to 5 p.m.

KERN COUNTY

Bakersfield
2530 "F" St., #100
Bakersfield
93301
661-633-2934

LOS ANGELES COUNTY

Bellflower
14359 Clark Ave.
Bellflower
90706
562-804-3119

Claremont
554 E. Baseline Road
Claremont
91711
909-626-4617

Lakewood
4206 Woodruff Ave.
Lakewood
90713
562-303-1436

Lancaster
2054 West Avenue "K"
Lancaster
93535
661-949-1824

Los Feliz
2654 Griffith Park Blvd.
Los Angeles
90039
323-906-1275

Pasadena
3655 E. Foothill Blvd.
Pasadena
91107
626-351-0175

Reseda
19367 Victory Blvd., #14
Reseda
91335
818-343-8116

South Bay
3525 Pacific Coast Hwy., #N
Torrance
90505
310-534-1113

Sun Valley
8341 Laurel Canyon Blvd.
Sun Valley
91352
818-768-6447

Torrance
19800 Hawthorne Blvd., #226
Torrance
90503
310-371-7984

Valencia
25914 N. McBean Pkwy.
Santa Clarita
91355
661-799-9965

West Los Angeles
1268 S. La Cienega Blvd.
Los Angeles
90035
310-854-0473

Whittier
13512 Whittier Blvd.
Whittier
90605
562-693-6106

ORANGE COUNTY

Anaheim
1801 W. Romneya Drive, #605
Anaheim
92801
714-956-2881

Huntington Beach
16490 Beach Blvd.
Westminster
92683
714-843-9797

Lake Forest
24352 Rockfield Blvd.
Lake Forest
92630
949-461-0166

Orange County
18220 Yorba Linda Blvd., #312
Yorba Linda
92886
714-993-5652

Yorba Linda
1041 Yorba Linda Blvd.
Placentia
92870
714-579-0717

RIVERSIDE COUNTY

Moreno Valley
27120 Eucalyptus Ave.
Suite #F
Moreno Valley
92555
951-488-0479

Palm Desert
72655 Highway 111, Suite B-3
Palm Desert
92260
760-340-9082

Riverside
3832 La Sierra Ave.
Riverside
92505
951-637-3722

Temecula
41880 Kalmia St.
Murrieta
92562
951-698-9807

SAN BERNARDINO COUNTY

Chino
3920 Grand Ave., Space 9
Suite #3920-E
Chino
91710
909-248-9112

Fontana
16940 Slover Ave., #A
Fontana
92337
909-854-8569

Redlands
415 E. Citrus Ave.
Redlands
92373
909-793-2631

SAN DIEGO COUNTY

Bonita
2220 Otay Lakes Road, #503
Chula Vista
91915
619-691-1108

Hillcrest
1244 University Ave.
San Diego
92103
619-291-0030

La Mesa
8066-68 La Mesa Blvd.
La Mesa
91941
619-644-9515

Oceanside
3870 Mission Ave.
Oceanside
92058
760-721-1141

Poway
14845 Pomerado Road
Poway
92064
858-435-0190

San Diego
7910 Frost St., #420
San Diego
92123
858-569-6090

Vista
1611 F S. Melrose Drive
Vista
92081
760-597-0050

La Jolla
8915 Towne Centre Drive
Suite 116
San Diego
92122
858-260-5615

VENTURA COUNTY

Camarillo
5800 Santa Rosa Road, #123
Camarillo
93012
805-482-9821

Ojai
1211 Maricopa Hwy., #109
Ojai
93023
805-646-4520

Thousand Oaks
3825 E. Thousand Oaks Blvd.
#O
Thousand Oaks
91362
805-496-1674

Ventura
3003 Loma Vista Road, #C
Ventura
93003
805-648-1685

KAISER PERMANENTE HEARING CENTERS

CENTRAL VALLEY

Modesto
4601 Dale Road, 2nd Floor
Modesto, CA 95356
209-735-3193
866-735-2922 TTY

Stockton
7373 West Lane
Stockton, CA 95210
209-476-5437
800-735-2922 TTY

DIABLO SERVICE AREA

Walnut Creek
710 South Broadway, Suite 209
Walnut Creek, CA 94596
925-295-4327
925-295-5177 TTY

EAST BAY

Oakland
2923 Webster St., Suite 201
Oakland, CA 94609
510-752-8330

FRESNO

1630 E. Shaw Avenue
Suite 124
Fresno, CA 93710
559-448-5640

GREATER ALAMEDA SERVICE AREA

Union City
3553 Whipple Road, Bldg. B
2nd Floor
Union City, CA 94587
510-675-2001
510-675-2002 TTY

NAPA/SOLANO

Vacaville
1 Quality Drive
Vacaville, CA 95688
707-624-3400

Vallejo
975 Sereno Drive
Vallejo, CA 94589
707-651-1055
800-735-2922 TTY

NORTH VALLEY

Roseville
2120 Professional Drive
Suite 220
Roseville, CA 95661
916-771-6680
916-771-6676 TTY

Sacramento
3180 Arden Way
Sacramento, CA 95825
916-977-3277
916-977-3282 TTY

REDWOOD CITY

1800 Broadway St., Suite 5
Redwood City, CA 94063
650-299-2977
800-735-2922 TTY

SAN FRANCISCO

4141 Geary Blvd., 1st Floor
San Francisco, CA 94118
415-833-8222
415-833-2400 TTY

SAN JOSE

5831 Cottle Road
San Jose, CA 95123
408-363-4801
800-735-2922 TTY

SAN RAFAEL

Novato
100 Rowland Way
Suite 125
Novato, CA 94945
415-209-2444
415-209-2440 TTY

SANTA CLARA

2894 Homestead Road
Santa Clara, CA 95051
408-553-6900
408-261-3144 TTY

SANTA ROSA

3333 Mendocino Ave.
Suite 240
Santa Rosa, CA 95403
707-566-5201
707-566-5259 TTY

SOUTH SACRAMENTO

7300 Wyndham Drive
Sacramento, CA 95823
916-525-6280
916-525-6098 TTY

SOUTH SAN FRANCISCO

Daly City
15 Southgate Ave., Suite 210
Daly City, CA 94015
650-758-5363
650-758-5371 TTY

blue of california

Self-Insured Schools of California
Effective October 1, 2020
PPO Plan

Summary of Benefits

80% Plan M $40 Copayment

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.[1] Please read both documents carefully for details.

Medical Provider Network: Full PPO Network

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Claims Administrator pays for Covered Services under the Plan. The Claims Administrator pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$3,000
	Family coverage	$3,000: individual
		$6,000: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$4,000
Family coverage	$4,000: individual
	$8,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services.

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		Not covered	
Physician services[10]				
Primary care office visit	$40/visit		50%	✔
Specialist care office visit	$40/visit		50%	✔
Physician home visit	$40/visit		50%	✔
Physician or surgeon services in an outpatient facility	20%	✔	50%	✔
Physician or surgeon services in an inpatient facility	20%	✔	50%	✔
Other professional services[10]				
Other practitioner office visit	$40/visit		50%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	20%	✔	50%	✔
Up to 12 visits per Member, per Calendar Year.				
Chiropractic services	20%	✔	Not covered	
Up to 20 visits per Member, per Calendar Year.				
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive	$0		Not covered	
• Diaphragm fitting	$0		Not covered	
• Intrauterine device (IUD)	$0		Not covered	
• Insertion and/or removal of intrauterine device (IUD)	$0		Not covered	
• Implantable contraceptive	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	20%	✔	Not covered	
• Diagnosis and Treatment of the Cause of Infertility	Not covered		Not covered	
Podiatric services	$40/visit		50%	✔
Pregnancy and maternity care[7, 10]				
Physician office visits: prenatal and postnatal	$40/visit		50%	✔
Physician services for pregnancy termination	20%	✔	Not covered	
Certified nurse midwives	20%	✔	20%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Emergency services				
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	$100/visit plus 20%	✔	$100/visit plus 20%	✔
Emergency room Physician services	20%	✔	20%	✔
Urgent care center services[10]	$40/visit		50%	✔
Ambulance services *This payment is for emergency or authorized transport.*	$100/transport plus 20%	✔	$100/transport plus 20%	✔
Outpatient facility services				
Ambulatory Surgery Center	20%	✔	All charges above $350	✔
Outpatient Department of a Hospital: surgery	20%	✔	All charges above $350	✔
Arthroscopy[8]	20% of up to $4,500/procedure plus 100% of additional charges	✔	Not covered	
Cataract Surgery[8]	20% of up to $2,000/procedure plus 100% of additional charges	✔	Not covered	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Inpatient facility services				
Hospital services and stay	20%	✔	All charges above $600	✔
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*				
• Special transplant facility inpatient services	20%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Physician inpatient services	20%	✔	Not covered	
Transplant Travel Benefit: Maximum payment will not exceed $10,000 per transplant, (not per lifetime) Ground transportation to and from the Center of Excellence (COE) when the desig-nated COE is 75 miles or more from the recipi-ent's or donor's place of residence. Coach air-fare to and from the COE when the designated COE is 300 miles or more from the recipient's or donor's residence.	All charges above $10,000/ transplant		Not covered	
Bariatric surgery services, designated California counties				
This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the outpatient facility services and Outpatient Physician services payments apply.				
Inpatient facility services	20%	✔	Not covered	
Outpatient facility services	20%	✔	Not covered	
Physician services	20%	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	20%	✔	Not covered	
• Outpatient Department of a Hospital	20%	✔	Not covered	
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	20%	✔	Not covered	
• Outpatient Department of a Hospital	20%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Other outpatient diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	20%	✔	Not covered	
• Outpatient Department of a Hospital	20%	✔	Not covered	
Radiological and nuclear imaging services				
• Outpatient radiology center	20%	✔	50%	✔
• Outpatient Department of a Hospital	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Colonoscopy[8]	20% of up to $1,500/procedure plus 100% of additional charges	✔	Not covered	
Upper GI Endoscopy[8]	20% of up to $1,000/procedure plus 100% of additional charges	✔	Not covered	
Upper GI Endoscopy with Biopsy[8]	20% of up to $1,250/procedure plus 100% of additional charges	✔	Not covered	
Rehabilitative and Habilitative Services				
Includes Physical Therapy, Occupational Therapy, and Respiratory Therapy.				
Office location	20%	✔	Not covered	
Outpatient Department of a Hospital	20%	✔	Not covered	
Speech Therapy services				
Office location	20%	✔	50%	✔
Outpatient Department of a Hospital	20%	✔	50%	✔
Durable medical equipment (DME)				
DME	20%	✔	Not covered	
Breast pump	$0		Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Orthotic equipment and devices *Up to 2 pairs of shoes and 2 inserts for therapeutic shoes per Calendar Year. Additional 2 pair of orthotics allowed post-surgery*	20%	✔	Not covered	
Prosthetic equipment and devices	20%	✔	50%	✔
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	20%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs and medical supplies.*	20%	✔	Not covered	
Home visits by an infusion nurse	20%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	20%	✔	Not covered	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*				
Freestanding SNF	20%	✔	20%	✔
Hospital-based SNF	20%	✔	All charges above $600	✔
Hospice program services				
Pre-Hospice consultation	$0		Not covered	
Routine home care	$0		Not covered	
24-hour continuous home care	$0		Not covered	
Short-term inpatient care for pain and symptom management	$0		Not covered	
Inpatient respite care	$0		Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Other services and supplies[10]				
Diabetes care services				
• Devices, equipment, and supplies	20%	✔	50%	✔
• Self-management training	$40/visit		50%	✔
Dialysis services	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
PKU product formulas and Special Food Products	20%	✔	Not covered	
Allergy serum billed separately from an office visit	20%	✔	50%	✔
Hearing services				
• Hearing aids and equipment *Up to $700 combined maximum per Member, per 24 months.*	20%	✔	20%	✔
• Audiological evaluations	$40/visit		50%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
	When using a Participating Provider or MHSA Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider or MHSA Non-Participating Provider[4, 9]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$40/visit		50%	✔
Intensive outpatient care	20%	✔	50%	✔
Behavioral Health Treatment in an office setting	20%	✔	50%	✔
Behavioral Health Treatment in home or other non-institutional setting	20%	✔	50%	✔
Office-based opioid treatment	20%	✔	50%	✔
Partial Hospitalization Program	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Psychological Testing	20%	✔	50%	✔
Inpatient services				
Physician inpatient services	20%	✔	50%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
	When using a Participating Provider or MHSA Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider or MHSA Non-Participating Provider[4, 9]	CYD[2] applies
Hospital services	20%	✔	All charges above $600	✔
Residential Care	20%	✔	All charges above $600	✔

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits
- Inpatient facility services
- Hospice program services

Please review the Benefit Booklet for more about Benefits that require prior authorization.

Notes

1 Benefit Booklet:

The Benefit Booklet describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

Capitalized terms are defined in the Benefit Booklet. Refer to the Benefit Booklet for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before the Claims Administrator pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by the Claims Administrator before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

This benefit Plan has a combined Participating Provider and Non-Participating Provider Calendar Year Deductible.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

Notes

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Any charges above the specified Benefit maximum are not covered, do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider.

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4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount, or
- any charges above the stated dollar amount, which is the Benefit maximum.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Charges above the Allowable Amount or Benefit maximum do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.
- Some Benefits from Non-Participating Providers have the Allowable Amount or Benefit maximum listed in the Benefits chart as a specific dollar ($) amount. You are responsible for any charges above the Allowable Amount or Benefit maximum, whether or not an amount is listed in the Benefits chart.

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5 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This benefit Plan has a combined Participating Provider and Non-Participating Provider OOPM. However, only the following Non-Participating Provider services will accrue to the combined OOPM:

- Ambulance services;
- Emergency services;
- Certified Nurse Midwives;
- Skilled nursing facilities (SNF) services at a Freestanding SNF; and
- Hearing aids and equipment.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

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6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example,

Notes

you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

8 Outpatient Facility Services

Services and supplies for the following Outpatient surgeries are subject to a Benefit maximum if performed in the Outpatient department of a Hospital: athroscopy, cataract surgery, colonoscopy, upper GI endoscopy, and upper GI endoscopy with biopsy. The Benefit maximum does not apply when the same services are provided in a participating Ambulatory Surgery Center.

9 For Services by Non-Preferred, Non-Participating and MHSA Non-Participating Providers:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

You are responsible for all charges above the Allowable Amount. However, if the Non-Preferred/Non-Participating/MHSA Non-Participating Provider is a Hospital based Physician performing Services at a Participating/MHSA Participating Provider (in-network) facility; or out of network lab services, when performed by an in-network (participating) provider, but sent to a non-participating provider for processing, the Claims Administrator's payment will be made at the Participating Provider copayment level.

Authorized Referrals for Services by Non-Preferred/Non-Participating//MHSA Non-Participating Providers –

In some circumstances, the Claims Administrator may authorize participating provider cost share amounts (Deductibles or Co-Payments, if applicable) to apply to a claim for a covered service you receive from a non-participating provider. In such circumstance, you or your physician must contact the Claims Administrator in advance of obtaining the covered service. It is your responsibility to ensure that the Claims Administrator has been contacted. If the Claims Administrator authorizes a participating provider cost share amount to apply to a covered service received from a non-participating provider, you also may still be liable for the difference between the maximum allowed amount and the non-participating provider's charge. Please call the customer service telephone number on the back of your ID card for authorized referral information or to request authorization.

Authorized referral occurs when you, because of your medical needs, are referred to a non-participating provider, but only when:

a. There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence;
b. You are referred in writing to the non-participating provider by the physician who is a participating provider, and
c. The referral has been authorized by the Claims Administrator before services are rendered. You or your physi-cian must call the toll-free telephone number printed on the back of your identification card prior to scheduling an admission to, or receiving the services of, a non-participating provider. Such authorized referrals are not available for transplant and bariatric surgical services. These services are only covered when performed at a COE.

10 First Dollar Coverage:

This Plan offers first dollar coverage for 3 office visits with Participating Providers. This means the Claims Administrator will pay for these Covered Services before you are charged a Copayment.

First dollar coverage is available for office visits with a Participating Physician, for any combination of these Provider types:

- General practice
- Family practice
- Internal Medicine
- Pediatrics
- Nurse Practitioner
- Physician's Assistant
- Obstetrics
- Gynecology

After you reach the 3 office visit maximum under the first dollar coverage benefit, additional office visits in the same Calendar Year are subject to the applicable Participating Provider office visit Copayment.

Non-Participating Provider office visits are not covered under the first dollar coverage. These services are covered as described in the Benefits chart above.

Plans may be modified to ensure compliance with Federal requirements.

LG031820

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

PLAN RX 7-25

	Walk-In				Mail	
	Network		Costco		Costco	Navitus
Days' Supply*	30	90	30	90	90	30
Generic	$7	N/A	**FREE**	**FREE**	**FREE**	N/A
Brand	$25	N/A	$25	$60	$60	N/A
Specialty	N/A	N/A	N/A	N/A	N/A	$25

Out-of-Pocket Maximum	$1,500 Individual / $2,500 Family

SISC urges members to use generic drugs when 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.

*Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies. Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs. Navitus contracts with most independent and chain pharmacies with the exception of Walgreens.

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**.

For information regarding the Prescription Drug Program call or visit on-line:
Navitus Customer Care 1-866-333-2757 (toll-free) TTY (toll free) 711 www.navitus.com

Navi-Gate® for Members allows you to access personalized pharmacy benefit information online at **www.navitus.com.** For information specific to your plan, visit Navi-Gate® for Members. Activate your account online using the Member Login link and an activation email will be sent to you. The site provides access to prescription benefits, pharmacy locator, drug search, drug interaction information, medication history, and mail order information. The site is available 24 hours a day, seven days a week.