SISC
Self-Insured Schools of California
Schools Helping Schools

Anthe Blue Cross Proposal

for

Glendale Community College District

June 4, 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

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.

Anthem BlueCross

Your summary of benefits

Anthem Blue Cross

Your Plan: Your Plan: SISC 90-G $20 Anthem Classic PPO

Your Network: Prudent Buyer PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation that may apply to the coverage. For more details, important limitations and exclusions, please review the Benefit Booklet. If there is a difference between this summary and the Benefit Booklet, the Benefit Booklet will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible for all providers (calendar year) *See notes section to understand how your deductible works.* *Fourth quarter carryover applies. Deductible applies to out-of-pocket maximum.*	$500 single / $1,000 family	
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. Member copays and coinsurance for Emergency medical care with a Non-Network PPO provider also apply to the In-Network PPO out-of-pocket maximums. See notes section for additional information regarding your out of pocket maximum.*	$1,000 single / $3,000 family	No limit single / No limit family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services		
Primary care visit to treat an injury or illness *Office visit copay does not apply to the first three office visits to In-Network providers. (See footnote 1)* *Deductible does not apply to In-Network providers.*	$0 copay per visit for visits 1-3, then $20 copay per visit for visits 4+.	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Specialist care visit *Deductible does not apply to In-Network providers.*	$20 copay per visit	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Prenatal and Post-natal Care *Office visit copay does not apply to the first three office visits to In-Network providers. (See footnote 1)* *Deductible does not apply to In-Network providers.*	$0 copay per visit for visits 1-3, then $20 copay per visit for visits 4+.	All billed amounts exceeding the maximum allowed amount. (See footnote 2)

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other practitioner visits:		
Retail health clinic *Deductible does not apply to In-Network providers.*	$20 copay per visit	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Preferred Online Visits *Includes Mental/Behavioral Health and Substance Abuse.* *Deductible does not apply to In-Network providers.*	$20 copay per visit	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Chiropractor services *Subject to medically necessity review administered by American Specialty Health (ASH).*	10% coinsurance	Not covered
Acupuncture *Coverage for In-Network Provider and Non-Network Provider combined is limited to 12-visit limit per calendar year. (See footnote 3)*	10% coinsurance	50% of maximum allowed amount (See footnote 2)
Other services in an office:		
Allergy testing	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Chemo/radiation therapy	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Hemodialysis *Coverage for Out-of-Network Provider is limited to $350 maximum per visit. (See footnote 3)*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services		
Lab:		
Office	10% coinsurance	Not covered
Freestanding Lab	10% coinsurance	Not covered
Outpatient Hospital	10% coinsurance	Not covered
X-ray:		
Office	10% coinsurance	Not covered
Freestanding Radiology Center	10% coinsurance	Not covered
Outpatient Hospital	10% coinsurance	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *Coverage for Out-of-Network Provider is limited to $800 maximum per test. (See footnote 3)*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Freestanding Radiology Center *Coverage for Out-of-Network Provider is limited to $800 maximum per test. (See footnote 3)*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $800 maximum per test. (See footnote 3)*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Emergency and Urgent Care		
Emergency room facility services *Copay waived if admitted as inpatient. This is for the hospital/facility charge only. The ER physician charge may be separate.*	$100 copay per admission and then 10% coinsurance	Covered at the In-Network level of benefits (See footnote 2)

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency room doctor and other services	10% coinsurance	Covered at the In-Network level of benefits (See footnote 2))
Ambulance (air and ground)	$100 copay per trip, then 10% coinsurance	Covered at the In-Network level of benefits (See footnote 2)
Urgent Care (physician services) *Deductible does not apply to In-Network providers.*	$20 copay per visit	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit *Deductible does not apply to In-Network providers.*	$20 copay per visit.	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Facility visit:		
Facility fees	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Outpatient Surgery		
Facility fees:		
Hospital	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Services and supplies for the following outpatient surgeries are subject to a benefit limit if performed in an outpatient hospital: ○ Arthroscopy limited to $4,500 per procedure ○ Cataract surgery limited to $2,000 per procedure ○ Colonoscopy limited to $1,500 per procedure ○ Upper GI Endoscopy limited to $1,000 per procedure ○ Upper GI Endoscopy with biopsy limited to $1,250 per procedure	10% coinsurance up to benefit limit	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Freestanding Ambulatory Surgical Center *Coverage for Out-of-Network Provider is limited to $350 maximum per day. (See footnote 3)*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Doctor and other services	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Coverage is limited to $600 benefit maximum per day for non-emergency admission at a Non-Network provider. (See footnote 3)*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Doctor and other services	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100-visit limit per calendar year. (See footnote 3)* *Coverage for Out-of-Network Provider is limited to $150 maximum per day. (See footnote 3)*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation Habilitation services (for example, physical/occupational therapy):		
Office	10% coinsurance	Not covered
Outpatient hospital	10% coinsurance	Not covered
Cardiac rehabilitation		
Office	10% coinsurance	Not covered
Outpatient hospital	10% coinsurance	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100-day limit per calendar year. (See footnote 3)* *Coverage for Out-of-Network Provider is limited to $600 maximum per day. (See footnote 3)*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Hospice *Deductible does not apply to In-Network providers.*	No charge	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Durable Medical Equipment	10% coinsurance	Not covered
Prosthetic Devices *Therapeutic shoes and inserts for members with diabetes are limited to 2 pairs per calendar year. (See footnote 3)*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Hearing Aids *Benefit is limited to $700 every 24 months. (See footnote 3)*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Hip/Knee/Spine *For inpatient services, this benefit is covered only when performed at a designated Blue Distinction Plus Center for Specialty Care. Subject to utilization review.*	10% coinsurance	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hemodialysis in an Outpatient facility *Coverage for Out-of-Network Provider is limited to $350 maximum per visit. (See footnote 3)*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Home Infusion Therapy *Coverage for Out-of-Network Provider is limited to $600 per day. Subject to utilization review. (See footnote 3)*	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Speech Therapy	10% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 2)

Footnote 1: The office visit copay is waived for the first three office visits to a primary care provider per calendar year. The copay waiver applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible. Primary care providers are defined as General and Family Practitioners, Internists, Gynecologists, Obstetrics/Gynecology, Pediatricians and Nurse Practitioners. The office visit copay will apply to all other provider specialties.

Footnote 2: When using Non-Network PPO Providers, members are responsible for any difference between the maximum allowed amount and actual charges, as well as any deductible & percentage copay.

Footnote 3: The plan may pay for the following services and supplies up to the maximum number of days or visits shown. When using non-network providers, the plan will pay the lesser of the benefit maximum or the maximum allowed amount. If the maximum allowed amount is less than the listed benefit maximum, the plan will not exceed the maximum allowed amount. Likewise, if the listed benefit maximum is less than the maximum allowed amount, the plan will not exceed the listed benefit maximum.

Your summary of benefits

Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, and coinsurance.
- In-network and out-of-network out of pocket maximums are exclusive of each other (i.e. non-emergency out-of-network expenses do not apply to the in-network out of pocket maximum).
- Any copays and coinsurance you make for covered services and supplies provided by a *non-participating provider,* except emergency services and supplies, will not be applied toward the satisfaction of your Out-of-Pocket amount. In addition, you will be required to continue to pay your copayment and/or coinsurance for such services even after you have reached that amount.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the maximum allowed amount. Members may be responsible for any amount in excess of the maximum allowed amount.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out of network benefit and you use a non-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Non-emergency, out-of-network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out of network benefits, all services with calendar/plan year visit limits are combined both in and out of network, except if otherwise noted.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.

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Your summary of benefits

- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Hip/Knee/Spine surgeries covered only when performed at Blue Distinction Plus Center for Specialty Care.
- Hip/Knee/Spine travel expenses are covered up to a maximum travel benefit of $6,000 when member's home is 50 miles or more from the nearest hip/knee/spine Blue Distinction Plus Center.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, please see your Benefit Booklet for full details on your covered benefits.

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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.

Your summary of benefits

Anthem BlueCross

Anthem Blue Cross

Your Plan: Custom Premier HMO 10/100%

Your Network: California Care HMO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$0	Not covered
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$1,000 single / $2,000 family	Not covered
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$10 copay per visit	Not covered
Specialist care visit	$10 copay per visit	Not covered
Prenatal and Post-natal Care	$10 copay per visit	Not covered
Other practitioner visits:		
Retail health clinic	$10 copay per visit	Not covered
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse.*	$10 copay per visit	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chiropractor services *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Chiropractor visits count towards your physical and occupational therapy limit.*	$10 copay per visit	Not covered
Acupuncture	$10 copay per visit	Not covered
Other services in an office:		
Allergy testing	$10 copay per visit	Not covered
Chemo/radiation therapy	$10 copay per visit	Not covered
Hemodialysis	$10 copay per visit	Not covered
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	$10 copay per visit	Not covered
Diagnostic Services		
Lab:		
Office	No charge	Not covered
Freestanding Lab	No charge	Not covered
Outpatient Hospital	No charge	Not covered
X-ray:		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	No charge	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *Costs may vary by site of service.*	$100 copay per test	Not covered
Freestanding Radiology Center *Costs may vary by site of service.*	$100 copay per test	Not covered
Outpatient Hospital *Costs may vary by site of service.*	$100 copay per test	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Emergency room facility services *This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.*	$100 copay per visit	Covered as In-Network
Emergency room doctor and other services	No charge	Covered as In-Network
Ambulance (air and ground)	$100 copay per trip for ground and air	Covered as In-Network
Urgent Care (office setting) *Copay waived if admitted. Costs may vary by site of service.*	$10 copay per visit	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$10 copay per visit.	Not covered
Facility visit:		
Facility fees	No charge	Not covered
Outpatient Surgery		
Facility fees:		
Hospital	No charge	Not covered
Freestanding Surgical Center	No charge	Not covered
Doctor and other services	No charge	Not covered
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	No charge	Not covered
Doctor and other services	No charge	Not covered
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider is limited to 100 visit limit per benefit period.*	$10 copay per visit	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service. Chiropractor visits count towards your physical and occupational therapy limit.*	$10 copay per visit	Not covered
Outpatient hospital *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service.*	$10 copay per visit	Not covered
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service. Chiropractor visits count towards your physical and occupational therapy limit.*	$10 copay per visit	Not covered
Outpatient hospital *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service.*	$10 copay per visit	Not covered
Cardiac rehabilitation		
Office	$10 copay per visit	Not covered
Outpatient hospital	$10 copay per visit	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Provider is limited to 100 day limit per benefit period.*	No charge	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment	No charge	Not covered
Prosthetic Devices	No charge	Not covered

Your summary of benefits

Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- Your plan requires a selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Infertility services are not included in the out of pocket amount.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_HMO
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

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Chiropractic Care and Acupuncture Rider Plan 10/30

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

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

Covered Services

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

Covered services include:

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

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

Covered services include:

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

Chiropractic Care and Acupuncture Rider Exclusions & Limitations

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

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

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

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

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

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

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

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

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

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

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

Third Party Liability

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

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Hearing Aid Rider

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

What Is Covered

Hearing Aid Services

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

Covered services include:

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

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

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

What Is Not Covered

Hearing Aid Services

The benefit does not include the following:

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

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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.

Anthem BlueCross

Your summary of benefits

Anthem Blue Cross

Your Plan: Value HMO 30/40/500/3 day

Your Network: California Care HMO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$0	Not covered
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$2,500 single / $5,000 family	Not covered
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$30 copay per visit	Not covered
Specialist care visit	$40 copay per visit	Not covered
Prenatal and Post-natal Care	$30 copay per visit	Not covered
Other practitioner visits:		
Retail health clinic	$30 copay per visit	Not covered
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse.*	$10 copay per visit	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chiropractor services *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Chiropractor visits count towards your physical and occupational therapy limit.*	$30 copay per visit	Not covered
Acupuncture	$30 copay per visit	Not covered
Other services in an office:		
Allergy testing	$30 copay per visit	Not covered
Chemo/radiation therapy	$40 copay per visit	Not covered
Hemodialysis	$40 copay per visit	Not covered
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	30% coinsurance up to $150 per visit	Not covered
Diagnostic Services		
Lab:		
Office	No charge	Not covered
Freestanding Lab	No charge	Not covered
Outpatient Hospital	No charge	Not covered
X-ray:		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	No charge	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *Costs may vary by site of service.*	$100 copay per test	Not covered
Freestanding Radiology Center *Costs may vary by site of service.*	$100 copay per test	Not covered
Outpatient Hospital *Costs may vary by site of service.*	$100 copay per test	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Emergency room facility services *This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.*	$150 copay per visit	Covered as In-Network
Emergency room doctor and other services	No charge	Covered as In-Network
Ambulance (air and ground)	$100 copay per trip for ground and air	Covered as In-Network
Urgent Care (office setting) *Copay waived if admitted. Costs may vary by site of service.*	$30 copay per visit	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$30 copay per visit.	Not covered
Facility visit:		
Facility fees	No charge	Not covered
Outpatient Surgery		
Facility fees:		
Hospital	$250 copay per admission	Not covered
Freestanding Surgical Center	$250 copay per admission	Not covered
Doctor and other services	No charge	Not covered
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *3 days copay max per admission*	$500 copay per day	Not covered
Doctor and other services	No charge	Not covered
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider is limited to 100 visit limit per benefit period.*	$30 copay per visit	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service. Chiropractor visits count towards your physical and occupational therapy limit.*	$30 copay per visit	Not covered
Outpatient hospital *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service.*	$40 copay per visit	Not covered
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service. Chiropractor visits count towards your physical and occupational therapy limit.*	$30 copay per visit	Not covered
Outpatient hospital *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service.*	$40 copay per visit	Not covered
Cardiac rehabilitation		
Office	$30 copay per visit	Not covered
Outpatient hospital	$40 copay per visit	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Provider is limited to 100 day limit per benefit period.*	No charge	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment	50% coinsurance	Not covered
Prosthetic Devices	No charge	Not covered

Your summary of benefits

Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- Your plan requires a selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Infertility services are not included in the out of pocket amount.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_HMO
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

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Chiropractic Care and Acupuncture Rider Plan 10/30

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

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

Covered Services

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

Covered services include:

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

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

Covered services include:

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

Chiropractic Care and Acupuncture Rider Exclusions & Limitations

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

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

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

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

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

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

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

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

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

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

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

Third Party Liability

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Hearing Aid Rider

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

What Is Covered

Hearing Aid Services

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

Covered services include:

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

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

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

What Is Not Covered

Hearing Aid Services

The benefit does not include the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss;
2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). Medically necessary surgically implanted hearing devices may be covered under your plan's benefits for prosthetic devices (see "Prosthetic Devices"); or
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Self-Insured Schools of California (SISC)
Pharmacy Benefit Schedule

PLAN RX 200DED/10-35

	Walk-In				Mail	
	Network		Costco		Costco	Navitus
Days' Supply*	30	90	30	90	90	30
Generic	$10	N/A	**FREE**	**FREE**	**FREE**	N/A
Brand	$35	N/A	$35	$90	$90	N/A
Specialty	N/A	N/A	N/A	N/A	N/A	$35

Out-of-Pocket Maximum	$2,500 Individual / $3,500 Family
Brand/Specialty Deductible	$200 Individual / $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. Monies paid in the 4th quarter (October-December) towards the deductible are carried over to the next calendar year.

*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)

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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®

YOUR KAISER PERMANENTE COMBINED CHIROPRACTIC AND ACUPUNCTURE BENEFIT

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.

YOUR KAISER PERMANENTE COMBINED CHIROPRACTIC AND ACUPUNCTURE BENEFIT

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.

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YOUR KAISER PERMANENTE COMBINED CHIROPRACTIC AND ACUPUNCTURE BENEFIT

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 ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ 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'dę́ę́', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 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).

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