SANTA ROSA JUNIOR COLLEGE

2016 OPEN ENROLLMENT MEDICAL PLANS

SANTA ROSA JUNIOR COLLEGE

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SANTA ROSA JUNIOR COLLEGE

2016 Enrollment Guidelines

Enrollment in a health plan begins the first of the month following the date of hire or triggering event.

Employees must provide proof of dependent eligibility when enrolling for the first time.

The documents listed below must be provided along with completed enrollment forms.

To enroll a spouse:

- Copy of a Marriage Certificate
- Copy of page one of Federal Tax Return (white out all income)

To enroll a domestic partner:

- Copy of Domestic Partner Affidavit or State of California Registration
- Copy of page one of both partner's Federal Tax Returns (white out all income)

To enroll a child:

- Copy of birth certificates for children up to age 26

The annual health plan open enrollment is the month of August. Any changes made to your medical plan become effective the following October 1st.

Please be aware, if you choose to enroll in an ABHP plan you are not eligible to participate in the Flexible Savings Account (FSA) for out of pocket medical expenses.

2016 HEALTH PLAN COMPARISON

	Kaiser HMO	Blue Shield HMO 25-500	Kaiser ABHP	Blue Shield ABHP	Blue Shield PPO
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOP)	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0/$0	$0/$0	$1,500/$3,000	$1,500/$3,000	$0/$0
Individual/Family Out-of-Pocket Max (includes deductibles and co-pays)	$1,500/$3,000	$2,000/$4,000	$3,000/$6,000	$3,425/$6,550	$1,000/$3,000
PROFESSIONAL SERVICES					
Office Visit co-pay	$25	$25	10%	10%	$30
Specialists/Consultants co-pay	$25	$30	10%	10%	$30
Prenatal, postnatal office visit co-pay	$0	$0	$0	10%	$30
Scans: CT, CAT, MRI, PET etc.	$0	$0	10%	10%	0%
Diagnostic X-ray & Laboratory Procedures	$0	$0	10%	10%	0%
Preventive Care Services (includes physical exams & screenings)	$0	$0	0%, Ded Waived	0%, Ded Waived	$0
HOSPITAL & SKILLED NURSING FACILITY SERVICES					
Emergency Room visit co-pay (waived if admitted)	$100	$100	10%	10% $100 co-pay	$100
Inpatient Hospital co-pay	$0	$500/admit	10%	10%	0%
Outpatient Hospital co-pay	$25	$500/admit	10%	10%	0%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	$25	$150	10%	10%	0%
Surgery, Outpatient (performed in a Hospital)	$25	$300	10%	10%	0%
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT					
INPATIENT CARE: Facility based care	$0	$500/admit	10%	10%	0%
OUTPATIENT CARE: Facility based care	$25	$25	10%	10%	$30
OTHER SERVICES					
Acupuncture - Limits may apply	$10/30 visits combined w/chiro	$10/30 visits combined w/chiro	Limited coverage, if authorized	10%	$0/12 visits
Ambulance (Ground or Air)	$50	$100	10%	10%	0%
Chiropractic - Limits may apply	$10/30 visits combined w/acu	$10/30 visits combined w/acu	Not covered	10%	$0/20 visits
Durable Medical Equipment (DME)	$0	20%	10%	10%	0%
Physical and Occupational Therapy - Limits may apply	$25	$25	10%	10%	0%
PRESCRIPTION DRUG PLANS					
Prescription Deductible	$0	$200/$500	Part of Medical Deductible	Part of Medical Deductible	$200/$500
Generic co-pay/days supply	$10/100-day	$10 / 30-day	After deductible, $10 / 30-day	After deductible, $7/ 30-day	$10 / 30-day
Brand co-pay/days supply	$25/100-day	After deductible, $35 / 30-day	After deductible, $30 / 30-day	After deductible, $25/30-day	After deductible, $35 / 30-day
Mail Order (Generic-Brand co-pay/days supply)	$10-25/100-day	Brand - after deductible, $90/90 / Generic - $0/90	After deductible, $20 - $60 / 100-day	After deductible, $14-25/90-day	Brand - after deductible, $90/90 / Generic - $0/90

2016 HEALTH PLAN COMPARISON

Rates - Single	$590	$637	$455	$553	$747
Rates - Double	$1,265	$1,355	$976	$1,216	$1,598
Rates - Family	$1,739	$1,888	$1,342	$1,713	$2,230
Health Savings Account District Contributions - Single / Double & Family			$1200/$1800	$1200/$1800	
Employee Monthly Portion 10/1/2016-9/30/2017 - Single Faculty amounts based on 10 months, Classified /Management based on 12 months	$0	Faculty $39.48, Classified and Management $32.90	$0	$0	Faculty $131.88, Classified and Management $109.90
Employee Monthly Portion 10/1/2016-9/30/2017 - Double Faculty amounts based on 10 months, Classified /Management based on 12 months	$0	Faculty $75.60 Classified and Management $63.00	$0	$0	Faculty $279.72, Classified and Management $233.10
Employee Monthly Portion 10/1/2016-9/30/2017 - Family Faculty amounts based on 10 months, Classified /Management based on 12 months	$0	Faculty $125.16, Classified and Management $104.30	$0	$0	Faculty $412.44, Classified and Management $343.70

NOTATIONS:

This is only a brief summary of benefits that reflects In-Network benefits. Please review the benefit summaries or plan booklets for details, limitations and exclusions.

OOP maximum on Blue Shield plans with a Navitus pharmacy carve out does not include prescription drug co-pays.

Health Savings Account Plans and Kaiser HMO or ABHP OOP maximum does include prescription drug co-pays.

For plans with a deductible, co-insurance applies after the deductible has been met unless otherwise noted.

SANTA ROSA JUNIOR COLLEGE

SISC BLUE SHIELD OF CALIFORNIA HEALTH PLANS

SISC BLUE SHIELD OF CALIFORNIA PPO HEALTH PLAN

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SISC BLUE SHIELD OF CALIFORNIA HMO HEALTH PLAN

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SISC BLUE SHIELD OF CALIFORNIA ACCOUNT BASED HEALTH PLAN (ABHP) ELIGIBLE FOR PARTICIPATION IN A HEALTH SAVINGS ACCOUNT (HSA)

SISC ASO
Blue Shield of California 100%
Plan A $30 Copayment
Benefit Summary
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective: October 1, 2016

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *PLAN CONTRACT* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

	Participating Providers[1]	Non-Participating Providers[2]
Calendar Year Medical Deductible (All providers combined)	None	
Calendar Year Out-of-Pocket Maximum[12] (Includes the calendar year medical deductible.)	$1,000 per individual / $3,000 per family	
Lifetime Benefit Maximum	None	

Covered Services	**Member Copayment**	
OUTPATIENT PROFESSIONAL SERVICES	**Participating Providers[1]**	**Non-Participating Providers[2]**
Professional (Physician) Benefits		
Physician and specialist office visits	$30 per visit	50%[12]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge	Not Covered
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge	50%[12]
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections (separate office visit copayment may apply)	No Charge	50%[12]
Preventive Health Benefits[11]		
Preventive health services (as required by applicable Federal law)	No Charge	Not Covered
OUTPATIENT FACILITY SERVICES		
Outpatient surgery performed at a free-standing ambulatory surgery center	No Charge	No Charge[3]
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	No Charge	No Charge[3]
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	No Charge	50%[12]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge	Not Covered
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge	50%[3, 12]
Bariatric surgery[4] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	No Charge	No Charge[3]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	No Charge	50%[12,13]
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	No Charge	No Charge[5]
Bariatric surgery[4] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	No Charge	No Charge[5]
Inpatient Skilled Nursing Benefits[6] (combined maximum of up to 100 days per calendar year; prior authorization is required; semi-private accommodations)		
Free-standing skilled nursing facility	No Charge	No Charge
Skilled nursing unit of a hospital	No Charge	No Charge[5]

EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$100 per visit	$100 per visit
Emergency room services resulting in admission (when the member is admitted directly from the ER)	No Charge	No Charge
Emergency room physician services	No Charge	No Charge
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	No Charge	No Charge
PRESCRIPTION DRUG COVERAGE		
Outpatient Prescription Drug Benefits	Administered by Navitus Health Solutions 1-866-333-2757	
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copayment may apply)	No Charge	50%[12]
Orthotic equipment and devices (separate office visit copayment may apply)	No Charge	Not Covered
DURABLE MEDICAL EQUIPMENT		
Breast pump	No Charge	Not Covered
Other durable medical equipment	No Charge	Not Covered
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES[8,9]		
Inpatient hospital services	No Charge	No Charge[5]
Residential care	No Charge	No Charge[5]
Inpatient physician services	No Charge	50%[12,13]
Routine outpatient mental health and substance abuse services (includes professional/physician visits)	$30 per visit	50%[12]
Non-routine outpatient mental health and substance abuse services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization program, psychological testing and transcranial magnetic stimulation)	No Charge	50%[12]
HOME HEALTH SERVICES		
Home health care agency services[6] (up to 100 visits per calendar year)	No Charge	Not Covered[10]
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	No Charge	Not Covered[10]
HOSPICE PROGRAM BENEFITS		
Routine home care	No Charge	Not Covered[10]
Inpatient respite care	No Charge	Not Covered[10]
24-hour continuous home care	No Charge	Not Covered[10]
Short-term inpatient care for pain and symptom management	No Charge	Not Covered[10]
CHIROPRACTIC BENEFITS[6]		
Chiropractic spinal manipulation (up to 20 visits per calendar year)	No Charge	Not Covered
ACUPUNCTURE BENEFITS[6]		
Acupuncture services (up to 12 visits per calendar year)	No Charge	50%[12]
REHABILITATION AND HABILITATION BENEFITS (Physical, Occupational and Respiratory Therapy)		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	No Charge	Not Covered
SPEECH THERAPY BENEFITS		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	No Charge	50%[12]
PREGNANCY AND MATERNITY CARE BENEFITS		
Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery services)	$30 per visit	50%[12]
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge	Not Covered
FAMILY PLANNING BENEFITS		
Counseling and consulting (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge	Not Covered
Tubal ligation	No Charge	Not Covered
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge	Not Covered

DIABETES CARE BENEFITS		
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	No Charge	50%[12]
Diabetes self-management training	$30 per visit	50%[12]
HEARING BENEFITS		
Audiological evaluations	$30 per visit	50%[12]
Hearing aid instrument and ancillary equipment (Up to a maximum combined benefit of $700 per person every 24 months for the hearing aid and ancillary equipment.)	No Charge	No Charge
CARE OUTSIDE OF PLAN SERVICE AREA		
Benefits provided through the BlueCard® Program are paid at the participating level. Member's cost share will be either a copayment or coinsurance based on the lower of billed charges or the negotiated allowable amount for participating providers as agreed upon with the local Blue's Plan.		
Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

1 Unless otherwise specified, copayments/coinsurance are calculated based on allowable amounts. After the calendar year medical deductible is met, the member is responsible for copayments/coinsurance for covered services from participating providers. Participating providers agree to accept Blue Shield's allowable amount plus any applicable member copayment or coinsurance as full payment for covered services.

2 Non-participating providers can charge more than Blue Shield's allowable amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year deductible or out-of-pocket maximum.

3 The maximum allowed charges for non-emergency surgery performed in a non-participating ambulatory surgery center or outpatient unit of a non-participating hospital is $350 per day. Members are responsible for all charges in excess of $350 per day.

4 Bariatric surgery is covered when prior authorized by Blue Shield; however, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other participating provider and there is no coverage for bariatric services from non-participating providers. In addition, if prior authorized by Blue Shield, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Plan Contract for further details.

5 The maximum allowed charges for non-emergency hospital services received from a non-participating hospital is $600 per day. Members are responsible for all charges in excess of $600 per day.

6 For plans with a calendar year medical deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the calendar year medical deductible has been met.

7 Services may require prior authorization. When services are prior authorized, members pay the participating provider amount.

8 Mental Health and Substance Abuse services are accessed through Blue Shield's participating and non-participating providers.

9 Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the Plan Contract for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's participating providers or non-participating providers.

10 Services from non-participating providers for home health care and hospice services are not covered unless prior authorized. When these services are prior authorized, the member's copayment or coinsurance will be calculated at the participating provider level, based upon the agreed upon rate between Blue Shield and the agency.

11 Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar year medical deductible and applicable member copayment/coinsurance.

12 Copayments/Coinsurance marked with this footnote do not accrue to the calendar year out-of-pocket maximum. Copayments/Coinsurance and charges for services not accruing to the member's calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached. This amount could be substantial. Please refer to the Plan Contract for exact terms and conditions of coverage.

13 When these services are rendered by a non-participating Radiologist, Anesthesiologist, Pathologist and/or Emergency Room Physician in a participating facility, the member pays the participating provider copayment.

Plan designs may be modified to ensure compliance with Federal requirements.

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

PLAN	RX 200DED/10-35				
	Walk-in			Mail	
	Network	**Costco**		**Costco**	Navitus
Days' Supply*	30	30	90	90	30
Generic	$10	**Free**	**Free**	**Free**	
Brand	$35	$35	$90	$90	
Specialty					$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.

*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

Lumicera Specialty Services 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**.

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.

SISC
Custom HMO 25-500 Admit Inpatient
Benefit Summary
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective: October 1, 2016

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Highlights: A description of the prescription drug coverage is provided separately

Calendar Year Medical Deductible	None
Calendar Year Out-of-Pocket Maximum	$2,000 per individual / $4,000 per family
Lifetime Benefit Maximum	None
Covered Services	**Member Copayment**
OUTPATIENT PROFESSIONAL SERVICES	
Professional (Physician) Benefits	
Physician and specialist office visits (note: a woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services)	$25 per visit
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge
Allergy Testing and Treatment Benefits	
Allergy testing, treatment and serum injections	$25 per visit
Access+ *Specialist*[SM] Benefits[1]	
Office visit, examination or other consultation (self-referred office visits and consultations only)	$30 per visit
Preventive Health Benefits	
Preventive health services (as required by applicable Federal and California law)	No Charge
OUTPATIENT FACILITY SERVICES	
Outpatient surgery performed at a free-standing ambulatory surgery center	$150 per surgery
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	$300 per surgery
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	No Charge
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge
HOSPITALIZATION SERVICES	
Hospital Benefits (Facility Services)	
Inpatient physician services	No Charge
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	$500 per admission
INPATIENT SKILLED NURSING BENEFITS[2,3] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)	
Free-standing skilled nursing facility	$100 per day
Skilled nursing unit of a hospital	$100 per day

EMERGENCY HEALTH COVERAGE	
Emergency room services not resulting in admission (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$100 per visit
Emergency room physician services	No Charge
AMBULANCE SERVICES	
Emergency or authorized transport (ground or air)	$100
PRESCRIPTION DRUG COVERAGE	
Outpatient Prescription Drug Benefits	Administered by Navitus Health Solutions 1-866-333-2757
PROSTHETICS/ORTHOTICS	
Prosthetic equipment and devices (separate office visit copayment may apply)	No Charge
Orthotic equipment and devices (separate office visit copayment may apply)	No Charge
DURABLE MEDICAL EQUIPMENT	
Breast pump	No Charge
Other durable medical equipment (member share is based upon allowed charges)	20%
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES[4, 5]	
Inpatient hospital services	$500 per admission
Residential care	$500 per admission
Inpatient physician services	No Charge
Routine outpatient mental health and substance abuse services (includes professional/physician visits)	$25 per visit
Non-routine outpatient mental health and substance abuse services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization programs, psychological testing and transcranial magnetic stimulation)	No Charge
HOME HEALTH SERVICES	
Home health care agency services[2] Coverage limited to 100 visits per member per calendar year.	$25 per visit
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	No Charge
HOSPICE PROGRAM BENEFITS	
Routine home care	No Charge
Inpatient respite care	No Charge
24-hour continuous home care	No Charge
Short-term inpatient care for pain and symptom management	No Charge
PREGNANCY AND MATERNITY CARE BENEFITS	
Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery services)	No Charge
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge
FAMILY PLANNING AND INFERTILITY BENEFITS	
Counseling and consulting (Includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge
Infertility services (member cost share is based upon allowed charges) (diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50%
Tubal ligation	No Charge
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge
REHABILITATION AND HABILITATION BENEFITS (Physical, Occupational and Respiratory Therapy)	
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	$25 per visit
SPEECH THERAPY BENEFITS	
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	$25 per visit
DIABETES CARE BENEFITS	
Devices, equipment, and non-testing supplies (member share is based upon allowed charges; for testing supplies see Outpatient Prescription Drug Benefits)	20%
Diabetes self-management training	$25 per visit

HEARING BENEFITS	
Audiological evaluations	$25 per visit
Hearing aid instrument and ancillary equipment (every 24 months for the hearing aid and ancillary equipment)	50%
URGENT CARE BENEFITS	
Urgent care services outside your personal physician service area within California	$25 per visit
Urgent care services outside of California (BlueCard® Program)	$25 per visit

OPTIONAL BENEFITS

Optional dental, vision, hearing aid, infertility, chiropractic or acupuncture benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

1 To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA.

2 For Plans with a facility deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the plan deductible has been met.

3 Inpatient skilled nursing services are limited to 100 preauthorized days during a benefit period except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on inpatient skilled nursing services is a combined maximum between skilled nursing services provided in a hospital unit and skilled nursing services provided in a skilled nursing facility (SNF).

4 Mental Health and Substance Abuse services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using MHSA participating providers.

5 Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the Evidence of Coverage for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield participating providers.

Plan designs may be modified to ensure compliance with state and federal requirements.

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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	30	90	90	30
Generic	$10	**Free**	**Free**	**Free**	
Brand	$35	$35	$90	$90	
Specialty					$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.

*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

Lumicera Specialty Services 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**.

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.

SISC
ASO PPO HSA Plan A
Benefit Summary

Blue Shield of California

Highlights: $1,500 individual contract deductible or $3,000 family contract deductible

Effective: October 1, 2016

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE BENEFITS AND IS A SUMMARY ONLY. THE *PLAN CONTRACT* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

	Participating Providers[1]	**Non-Participating Providers[1]**
Calendar Year Medical Deductible (All providers combined; No 4th quarter carryover) (Note: For family coverage, the full family deductible must be met before the enrollee or covered dependents can receive benefits for covered services (one or more in the family can satisfy the family deductible).	$1,500 per individual contract / $3,000 per family Single Insured Person - $1,500 /Insured person Family (includes insured person & one or more insured persons of the employee's family; no coverage may be paid for any family insured person unless this $3,000 deductible is met)	
Calendar Year Out-of-Pocket Maximum[2] (Includes the calendar year medical deductible) For individual on family coverage plan, enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met. All providers combined accumulate toward the calendar year out-of-pocket maximum.	$3,425 per individual / $6,550 per family	
Lifetime Benefit Maximum	None	
Covered Services	**Member Copayment**	
OUTPATIENT PROFESSIONAL SERVICES	**Participating Providers[1]**	**Non-Participating Providers[1]**
Professional (Physician) Benefits		
Physician and specialist office visits	10%	50%[2]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	10%	Not Covered
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	10%	50%[2]
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections (separate office visit copayment may apply)	10%	50%[2]
Preventive Health Benefits[22]		
Preventive health services (as required by applicable Federal law)	No Charge (not subject to the calendar year medical deductible)	Not Covered
OUTPATIENT FACILITY SERVICES		
Outpatient surgery performed at a free-standing ambulatory surgery center	10%	No Charge[3]
Outpatient surgery performed in a hospital or hospital affiliated ambulatory surgery center	10%	No Charge[3]
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	10%	50%[2]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	10%	Not Covered
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	10%	50%[2,3]
Bariatric surgery[4] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	10%	No Charge[3]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	10%	50%[2,8]
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	10%	No Charge[5]
Bariatric surgery[4] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	10%	No Charge[5]

Inpatient Skilled Nursing Benefits[6] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)		
Free-standing skilled nursing facility	10%	10%[7]
Skilled nursing unit of a hospital	10%	No Charge[5]
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$100 per visit + 10%	$100 per visit + 10%
Emergency room services resulting in admission (when the member is admitted directly from the ER)	10%	10%
Emergency room physician services	10%	10%[8]
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	10%	10%
PRESCRIPTION DRUG COVERAGE[9,10,11,12,13,14,15,16,17,18] (subject to deductible)	**Participating Pharmacy**	**Non-Participating Pharmacy**
Outpatient Prescription Drug Benefits		
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[15]	No Charge	Not Covered
Formulary generic drugs	$9 per prescription	$9 per prescription
Formulary brand drugs	$35 per prescription	$35 per prescription
Non-Formulary brand drugs	$35 per prescription	$35 per prescription
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[15]	No Charge	Not Covered
Formulary generic drugs	$18 per prescription	Not Covered
Formulary brand drugs	$90 per prescription	Not Covered
Non-Formulary brand drugs	$90 per prescription	Not Covered
Specialty Pharmacies[12,14] (up to a 30-day supply)		
Specialty drugs (includes orally administered anti-cancer medications)	$35 per prescription	Not Covered
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copayment may apply)	10%	50%[2]
Orthotic equipment and devices (separate office visit copayment may apply)	10%	Not Covered
DURABLE MEDICAL EQUIPMENT		
Breast pump	No Charge (not subject to the calendar year medical deductible)	Not Covered
Other durable medical equipment	10%	No Charge
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES[19,20]		
Inpatient hospital services	10%	No Charge[5]
Residential care	10%	No Charge[5]
Inpatient physician services	10%	50%[2]
Routine outpatient mental health and substance abuse services (includes professional/physician visits)	10%	50%[2]
Non-routine outpatient mental health and substance abuse services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization program, psychological testing and transcranial magnetic stimulation)	10%	50%[2]
HOME HEALTH SERVICES	**Participating Providers**[1]	**Non-Participating Providers**[2]
Home health care agency services[6] (up to 100 visits per calendar year)	10%	Not Covered[21]
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	10%	Not Covered[21]
HOSPICE PROGRAM BENEFITS[21]		
Routine home care	10%	Not Covered[21]
Inpatient respite care	10%	Not Covered[21]
24-hour continuous home care	10%	Not Covered[21]
Short-term inpatient care for pain and symptom management	10%	Not Covered[21]
CHIROPRACTIC BENEFITS[6]		
Chiropractic spinal manipulation (up to 20 visits per calendar year)	10%	Not Covered
ACUPUNCTURE BENEFITS[6]		
Acupuncture services (up to 12 visits per calendar year)	10%	50%[2]

REHABILITATION and HABILITATION BENEFITS (Physical, Occupational and Respiratory Therapy)		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	10%	Not Covered
SPEECH THERAPY BENEFITS		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	10%	50%[2]
PREGNANCY AND MATERNITY CARE BENEFITS		
Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery services)	10%	50%[2]
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	10%	Not Covered
FAMILY PLANNING BENEFITS		
Counseling and consulting (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge (not subject to the calendar year medical deductible)	Not Covered
Tubal ligation (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge (not subject to the calendar year medical deductible)	Not Covered
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	10%	Not Covered
DIABETES CARE BENEFITS		
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	10%	50%[2]
Diabetes self-management training	10%	50%[2]
HEARING BENEFITS		
Audiological evaluations	10%	50%[2]
Hearing aid instrument and ancillary equipment (Up to a maximum combined benefit of $700 per pair every 24 months for the hearing aid and ancillary equipment.)	10%	10%
CARE OUTSIDE OF PLAN SERVICE AREA Benefits provided through the BlueCard® Program are paid at the participating level. Member's cost share will be either a copayment or coinsurance based on the lower of billed charges or the negotiated allowable amount for participating providers as agreed upon with the local Blue's Plan.		
Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

1 Unless otherwise specified, copayments/coinsurance are calculated based on allowable amounts. Participating providers agree to accept Blue Shield's allowable amount plus the plan's and any applicable member's payment as full payment for covered services. Non-Participating providers can charge more than these amounts. When members use Non-Participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges in excess of the allowable amount do not count toward the Calendar Year deductible or out-of-pocket maximum. Payments applied to your Calendar Year deductible accrue towards the out-of-pocket maximum.

2 Copayments/Coinsurance marked with this footnote does not accrue to Calendar Year out-of pocket maximum. Copayments/Coinsurance and charges for services not accruing to the member's Calendar Year out-of-pocket maximum continue to be the member's responsibility after the Calendar Year out-of-pocket maximum is reached. This amount could be substantial. Please refer to the Plan Contract for exact terms and conditions of coverage.

3 The maximum allowed charges for non-emergency surgery and services performed in a non-participating ambulatory surgery center or outpatient unit of a non-participating hospital is $350 per day. Members are responsible for 0% of this $350 per day, and all charges in excess of $350 per day. Amounts that exceed the benefit maximums do not count toward the calendar year out-of-pocket maximum and continue to be the member's financial responsibility after the calendar year maximums are reached.

4 Bariatric surgery is covered when prior authorized by Blue Shield; however, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons. Coverage is not available for bariatric services from any other participating provider and there is no coverage for bariatric services from non-participating providers. In addition, if prior authorized by Blue Shield, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Plan Contract for further details.

5 The maximum allowed charges for non-emergency hospital services received from a non-participating hospital is $600 per day. Members are responsible for 0% of this $600 per day, and all charges in excess of $600 per day. Amounts that exceed the benefit maximum do not count toward the calendar year out-of-pocket maximum and continue to be the member's responsibility after the calendar year maximums are reached.

6 For plans with a calendar year medical deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the calendar year medical deductible has been met.

7 Services may require prior authorization. When services are prior authorized, members pay the participating provider amount.

8 When these services are rendered by a Non-Participating Radiologist, Anesthesiologist, Pathologist and Emergency Room Physicians in a Participating facility, the member pays the Participating Provider copayment.

9 If the member requests a brand drug when a generic drug equivalent is available, the member is responsible for paying the difference in cost between the brand drug and its generic drug equivalent, in addition to the generic drug copayment. The difference in cost that the member must pay does not accrue to any calendar year medical or brand drug deductible and is not included in the calendar year out-of-pocket maximum responsibility calculations. Refer to the Plan Contract for details.

10 Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.

11 Outpatient prescription drug copayments for covered drugs obtained from non-participating pharmacies will accrue to the participating provider maximum calendar year out-of-pocket maximum.

12 Specialty drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides specialty drugs by mail or upon member request, at an associated retail store for pickup.

13 Select formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, or when effective, lower cost alternatives are available.

14 Specialty Drugs are Drugs requiring coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy and are available at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.

15 Contraceptive drugs and devices covered under the outpatient prescription drug benefits do not require a copayment and are not subject to the calendar year medical deductible when obtained from a participating pharmacy. However, if a brand contraceptive is requested when a generic equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic drug equivalent. The difference in cost that the member must pay does not accrue to any calendar year medical or brand drug deductible and is not included in the calendar year out-of-pocket maximum calculation. In addition, select contraceptives may need prior authorization to be covered without a copayment.

16 To obtain prescription drugs at a non-participating pharmacy, the member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. The member will be reimbursed the price paid for the drug less any applicable deductible, copayment or coinsurance (Generic, Formulary Brand, or Non-Formulary Brand) and any applicable out of network charge.

17 To obtain contraceptive drugs and devices at a non-participating pharmacy, the member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. The member will be reimbursed the price paid for the drug less any applicable deductible, copayment or coinsurance (Generic, Formulary Brand, or Non-Formulary Brand) and any applicable out of network charge.

18 Blue Shield's Short-Cycle Specialty Drug Program allows initial prescriptions for select specialty drugs to be dispensed for a 15-day trial supply, as further described in the Plan Contract. In such circumstances, the applicable specialty drug copayment or coinsurance will be pro-rated.

19 Mental Health and Substance Abuse services are accessed through Blue Shield's Participating and Non-Participating providers.

20 Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the Plan Contract for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's participating providers or non-participating providers.

21 Services from non-participating providers for home health care and hospice services are not covered unless prior authorized. When these services are prior authorized, the member's copayment or coinsurance will be calculated at the participating provider level, based upon the agreed upon rate between Blue Shield and the agency.

22 Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar year medical deductible and applicable member copayment/coinsurance.

Plan designs may be modified to ensure compliance with Federal requirements.

SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

June 17, 2016

TO: Superintendent and Key Contact of Select SISC III Member Districts

FROM: SISC III Health Benefits

SUBJECT: Anthem and Blue Shield HSA-A Plan Design Changes Effective 1/1/2017

In an effort to comply with the new state legislation AB 1305, the following change to the Anthem and Blue Shield **HSA-A** plans will be effective January 1, 2017.

Anthem and Blue Shield HSA-A Current Plan Design		**Anthem and Blue Shield HSA-A New Plan Design Effective 1/1/2017**	
Deductible			
Single Coverage – Employee Only	$1,500	Single Coverage – Employee Only	$1,500
Family Coverage – Individuals enrolled on a plan with two or more members	$3,000	**Family Coverage – Individuals enrolled on a plan with two or more members**	**$2,600**
Maximum per Family	$3,000	Maximum per Family	$3,000
Out of Pocket Maximum			
Single Coverage – Employee Only	$3,425	**Single Coverage – Employee Only**	**$3,000**
Family Coverage – Individuals enrolled on a plan with two or more members	$6,550	**Family Coverage – Individuals enrolled on a plan with two or more members**	**$3,000**
Maximum per Family	$6,550	**Maximum per Family**	**$6,000**

This notice is being sent to all districts offering Anthem or Blue Shield plans, including those who do not currently offer this plan.

If your district will be offering the Anthem or Blue Shield HSA-A plan as of January 1, 2017, you will receive further communication regarding group number changes that are required to accommodate these plan design updates.

Please notify your employees and retirees as you determine appropriate. If you have any questions, you may contact your SISC Account Management Team at 661-636-4410.

SANTA ROSA JUNIOR COLLEGE

SISC KAISER PERMANENTE

HEALTH PLANS

SISC KAISER PERMANENTE HMO HEALTH PLAN

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SISC KAISER PERMANENTE ACCOUNT BASED HEALTH PLAN (ABHP) ELIGIBLE FOR PARTICIPATION IN A HEALTH SAVINGS ACCOUNT (HSA)

Benefit Summary

SISC - SELF-INSURED SCHOOLS OF CALIFORNIA.

Principal Benefits for Kaiser Permanente Traditional Plan (10/1/16—9/30/17)

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

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

Accumulation Period

The Accumulation Period for this plan is 1/1/16 through 12/31/16 (calendar year).

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year

Plan Deductible	None

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$25 per visit
Most Physician Specialist Visits	$25 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
Hearing exams	No charge
Urgent care consultations, evaluations, and treatment	$25 per visit
Most physical, occupational, and speech therapy	$25 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$25 per procedure
Allergy injections (including allergy serum)	$5 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

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

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

Note: This Cost Share does not apply if 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 at a Plan Pharmacy or through our mail-order service:	
Most generic items	$10 for up to a 100-day supply
Most brand-name items	$25 for up to a 100-day supply

Durable Medical Equipment (DME)	**You Pay**
DME items in accord with our DME formulary guidelines	No charge

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$25 per visit

Proposed Benefit Summary *(continued)*

Group outpatient mental health treatment	$12 per visit
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$25 per visit
Group outpatient chemical dependency treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices	No charge
Hospice care	No charge

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.
   - Online at ashlink.com/ash/kp, or
   - Call **1-800-678-9133** or **711** (TTY), weekdays 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.

Grievances

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

Exclusions and Limitations

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

Definitions

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

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

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

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

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

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

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

(continues)

Definitions *(continued)*

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

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

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

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

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

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

Benefit Summary

SISC - Self-Insured Schools of California

Principal Benefits for Kaiser Permanente HSA-Qualified Deductible HMO Plan (10/1/16—9/30/17)

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

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

"Kaiser Permanente HSA-Qualified Deductible HMO Plan" is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This health benefit plan is a High Deductible Health Plan. The health care coverage described in the *EOC* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law. For information about who is eligible to contribute to an HSA, refer to your Group's enrollment materials or consult with your tax advisor.

Accumulation Period

The Accumulation Period for this plan is 1/1/16 through 12/31/16 (calendar year).

Plan Out-of-Pocket Maximum

You will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay, plus all your payments toward the Plan Deductible, add up to one of the following amounts:

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

Plan Deductible

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

For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year

Note: The Plan Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	10% Coinsurance after Plan Deductible
Most Physician Specialist Visits	10% Coinsurance after Plan Deductible
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	10% Coinsurance (Plan Deductible doesn't apply)
Hearing exams	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	10% Coinsurance after Plan Deductible
Most physical, occupational, and speech therapy	10% Coinsurance after Plan Deductible

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	10% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	10% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	10% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
Covered individual health education counseling	No charge (Plan Deductible doesn't apply)
Covered health education programs	No charge (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

Ambulance Services	**You Pay**
Ambulance Services	10% Coinsurance after Plan Deductible

Proposed Benefit Summary *(continued)*

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 after Plan Deductible
Most generic refills through our mail-order service	$20 for up to a 100-day supply after Plan Deductible
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply after Plan Deductible
Most brand-name refills through our mail-order service	$60 for up to a 100-day supply after Plan Deductible

Durable Medical Equipment (DME)	You Pay
DME items that are essential health benefits in accord with our DME formulary guidelines	10% Coinsurance after Plan Deductible
DME items that are not essential health benefits in accord with our DME formulary guidelines up to a $2,500 benefit limit per calendar year as described in the *EOC*	10% Coinsurance after Plan Deductible

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	10% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	10% Coinsurance after Plan Deductible
Group outpatient mental health treatment	10% Coinsurance after Plan Deductible

Chemical Dependency Services	You Pay
Inpatient detoxification	10% Coinsurance after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment	10% Coinsurance after Plan Deductible
Group outpatient chemical dependency treatment	10% Coinsurance after Plan Deductible

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

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	10% Coinsurance after Plan Deductible
Prosthetic and orthotic devices	No charge after Plan Deductible
Hospice care	No charge after Plan Deductible

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).

SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

June 17, 2016

TO: Superintendent and Key Contact of Select SISC III Member Districts

FROM: SISC III Health Benefits

SUBJECT: Kaiser HSA-A $1500 Plan Design Changes Effective 1/1/2017

The Kaiser HSA (Health Savings Account) medical plans must be consistent with state guidelines. To comply with the new state legislation AB 1305, the following change to the Kaiser **HSA-A $1,500** plan will be effective January 1, 2017.

Kaiser HSA-A $1,500 Current Plan Design		**Kaiser HSA-A $1,500 New Plan Design Effective 1/1/2017**	
Deductible			
Single Coverage – Employee Only	$1,500	Single Coverage – Employee Only	$1,500
Family Coverage – Individuals enrolled on a plan with two or more members	$3,000	**Family Coverage – Individuals enrolled on a plan with two or more members**	**$2,600**
Maximum per Family	$3,000	Maximum per Family	$3,000
Out of Pocket Maximum			
Single Coverage – Employee Only	$3,000	Single Coverage – Employee Only	$3,000
Family Coverage – Individuals enrolled on a plan with two or more members	$6,000	**Family Coverage – Individuals enrolled on a plan with two or more members**	**$3,000**
Maximum per Family	$6,000	Maximum per Family	$6,000

This notice is being sent to all districts in the Kaiser service area, including those who do not currently offer this plan. Please notify your employees and retirees as you determine appropriate.

If you have any questions, you may contact your SISC Account Management Team at 661-636-4410.

SANTA ROSA JUNIOR COLLEGE

ADDITIONAL BENEFITS PROVIDED BY SISC

GRAND ROUNDS

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EMPLOYEE ASSISTANCE PROGRAM (EAP)

When Should Members Use Grand Rounds?

GRAND ROUNDS™

Grand Rounds is a powerful addition to SISC's benefits program. To ensure that members get the most out of the offering, please follow the guidance below for helping members and covered dependents use our service.

GRAND ROUNDS **OPINIONS**

A second opinion delivered remotely from a world-leading expert specializing in the area of need - no travel required.

Members and their covered dependents should use Grand Rounds when they:

- Have a documented diagnosis from a doctor, and would like an expert's second opinion regarding the diagnosis or treatment plan
- Find themselves confronting a complex medical condition
- Would like their medications or treatment plan reviewed
- Are scheduled for surgery or a major procedure

Key facts

- Grand Rounds service is free
- Experts come from top institutions around the country such as Harvard and UCLA
- Plan guidelines apply for treatment that results from the opinion
- Top 0.1% of physicians in the world review cases
- 66% of cases result in a change in the diagnosis or treatment plan
- Gives peace of mind: members know they are making the right decisions
- Turnaround is typically about two weeks

GRAND ROUNDS **VISITS**

An in-person office visit with a highly-ranked physician in the patient's insurance network.

Members and their covered dependents should use Grand Rounds when they:

- Want to see a physician in-person, within their insurance network
- Recently moved and need to find new doctors
- Are looking for new doctors for their children
- Need to see a new type of specialist
- Want to make sure their treating physician is best suited for their exact medical needs

Key facts

- Grand Rounds service is free
- Grand Rounds uses a proprietary scoring system to identify top, in-network doctors
- Normal copays apply for the appointment
- Saves time: Grand Rounds can both find the physician and set the appointment
- Saves hassle: Grand Rounds handles transfer of medical records
- Turnaround is typically one to two days

How to refer to Grand Rounds:

1. Direct patient to call the Care Team: 1-844-252-3056
2. Direct patient to grandrounds.com/sisc
3. Send a personalized invitation: grandrounds.com/sisc/refer

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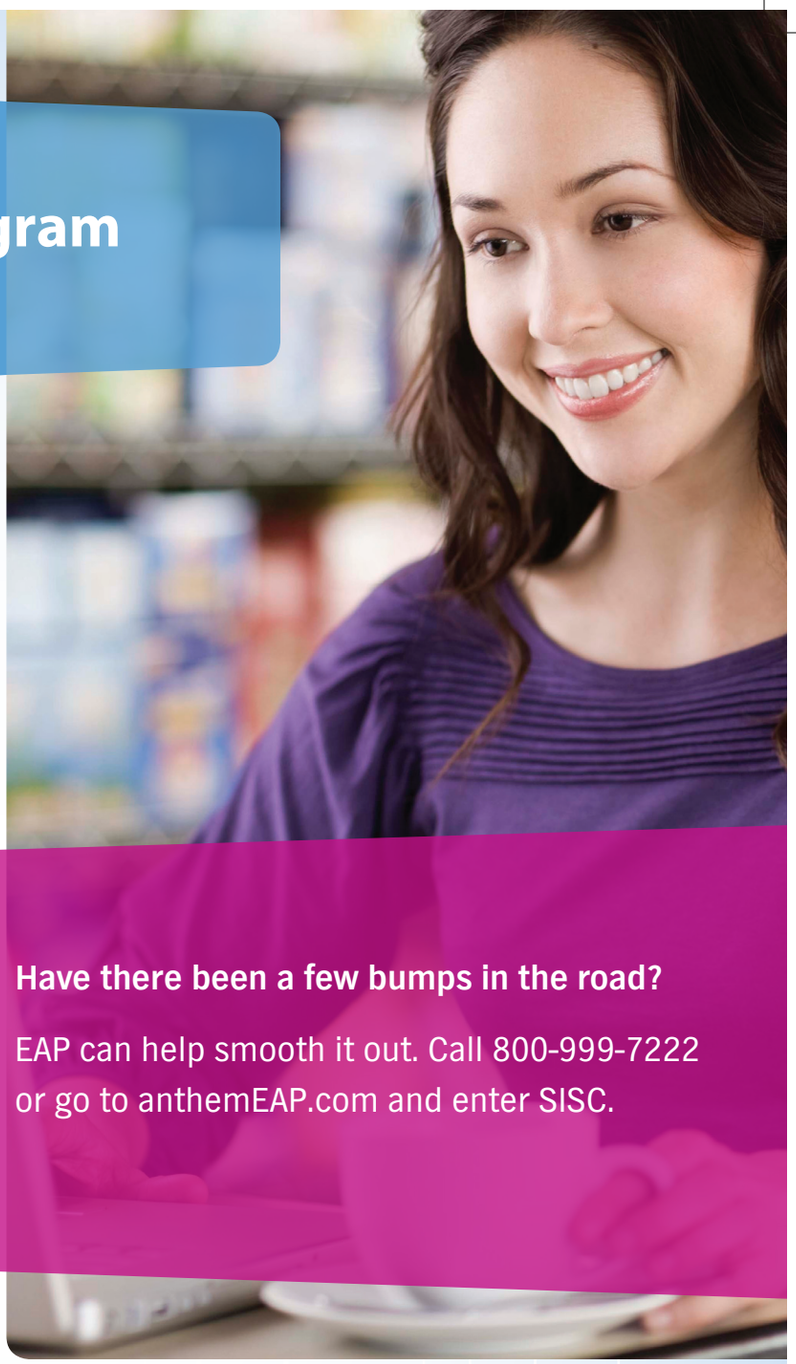
Schools Helping Schools

Employee Assistance Program



Have questions about home, work or family?

Maybe you're a few months behind on bills and want to get back on track. Or you're new to town and looking for a daycare center. Whatever your concern, a call to the Employee Assistance Program (EAP) can help you through it.

What is EAP anyway?

You may have heard about EAP but aren't sure what it is. EAP is a service available to you and members of your household at no extra cost. It's designed to help you with everyday problems and questions, big or small. No need to fill out paperwork or make an appointment to speak with an EAP staff member. Just call 800-999-7222 or visit anthemEAP.com. You'll be connected in an instant, and we're here 24 hours a day, every day, to help you.

How we can help

When you or a household member contacts us, we'll work with you to figure out the next steps. If you need counseling, we can arrange several free visits with a licensed professional. If you have money or legal questions, we can put you in touch with a financial advisor or a lawyer.

If online help is more your style, visit anthemEAP.com. You'll find articles, checklists, quizzes and other helpful tools. You can browse resources, attend a webinar or take an online class—right at your own desk. Here are just some of the topics covered:

- Workplace safety
- Child and elder care resources
- Tobacco cessation
- Grief and loss
- Family health
- Home improvement
- Addiction and recovery
- Dealing with identity theft

Have there been a few bumps in the road?

EAP can help smooth it out. Call 800-999-7222 or go to anthemEAP.com and enter SISC.

Remember, EAP is here for you 24/7, so you can call at the time and place that are right for you. Your privacy is important to us. No one will know you've called EAP unless you give them permission in writing.*

Anthem® BlueCross®

*In accordance with federal and state law, and professional ethical standards.

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