SISC BLUE SHIELD OF CALIFORNIA

HEALTH PLANS

SISC BLUE SHIELD OF CALIFORNIA PPO HEALTH PLAN

SISC BLUE SHIELD OF CALIFORNIA HMO HEALTH PLAN

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

**Blue Shield of California**

**Effective:** October 1, 2015

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Participating Providers $</th>
<th>Non Participating Providers $</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROFESSIONAL SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional (Physician) Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physician and specialist office visits</td>
<td>$30 per visit</td>
<td>50%</td>
</tr>
<tr>
<td>- CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)</td>
<td>No Charge</td>
<td>50%</td>
</tr>
<tr>
<td>- Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Allergy Testing and Treatment Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Office visits (includes visits for allergy serum injections)</td>
<td>No Charge</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Preventive Health Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Preventive Health Services (As required by applicable federal law.)</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>OUTPATIENT SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Benefits (Facility Services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Outpatient surgery performed at an Ambulatory Surgery Center</td>
<td>No Charge</td>
<td>No Charge$^b$</td>
</tr>
<tr>
<td>- Outpatient surgery in a hospital</td>
<td>No Charge</td>
<td>No Charge$^b$</td>
</tr>
<tr>
<td>- Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under &quot;Rehabilitation Benefits&quot;)</td>
<td>No Charge</td>
<td>50%</td>
</tr>
<tr>
<td>- CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)$^3$</td>
<td>No Charge</td>
<td>50%$^2, 3$</td>
</tr>
<tr>
<td>- Other outpatient X-ray, pathology and laboratory performed in a hospital$^3$</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>- Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)$^6$</td>
<td>No Charge</td>
<td>No Charge$^b$</td>
</tr>
<tr>
<td><strong>HOSPITALIZATION SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Benefits (Facility Services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Inpatient Physician Services</td>
<td>No Charge</td>
<td>50%$^2, 1b$</td>
</tr>
<tr>
<td>- Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)</td>
<td>No Charge</td>
<td>No Charge$^1$</td>
</tr>
<tr>
<td>- Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)$^6$</td>
<td>No Charge</td>
<td>No Charge$^1$</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Benefits$^5$</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Services by a free-standing Skilled Nursing Facility</td>
<td>No Charge</td>
<td>No Charge$^b$</td>
</tr>
<tr>
<td>- Skilled Nursing Unit of a Hospital</td>
<td>No Charge</td>
<td>No Charge$^b$</td>
</tr>
<tr>
<td><strong>EMERGENCY HEALTH COVERAGE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Emergency room Services not resulting in admission (The ER copayment does not apply if the member is directly admitted to the hospital for inpatient services)</td>
<td>$100 per visit</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>- Emergency room Services resulting in admission (when the member is admitted directly from the ER)</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>- Emergency room Physician Services</td>
<td>No Charge</td>
<td>No Charge$^{1b}$</td>
</tr>
</tbody>
</table>

*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.*
# AMBULANCE SERVICES
- Emergency or authorized transport: No Charge

# PRESCRIPTION DRUG COVERAGE
**Outpatient Prescription Drug Benefits**
- Administered by Navitus Health Solutions 1-866-333-2757

## PROSTHETICS/ORTHOTICS
- Prosthetic equipment and devices: No Charge (Separate office visit copay may apply)
- Orthotic equipment and devices: No Charge (Separate office visit copay may apply)

## DURABLE MEDICAL EQUIPMENT
- Breast pump: No Charge
- Other Durable Medical Equipment: No Charge

## MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services</td>
<td>No Charge</td>
</tr>
<tr>
<td>Residential Care</td>
<td>No Charge</td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>No Charge</td>
</tr>
<tr>
<td>Routine Outpatient Mental Health and Substance Abuse Services</td>
<td>$30 per visit</td>
</tr>
<tr>
<td>(includes professional/physician visits)</td>
<td>50%²</td>
</tr>
<tr>
<td>Non-Routine Outpatient Mental Health and Substance Abuse Services</td>
<td>No Charge</td>
</tr>
<tr>
<td>(includes behavioral health treatment, electroconvulsive therapy, Intensive outpatient programs, office-based opioid treatment, partial hospitalization programs, and transcranial magnetic stimulation. For partial hospitalization programs, a higher copayment and facility charges may apply per episode of care)</td>
<td></td>
</tr>
</tbody>
</table>

## HOME HEALTH SERVICES
- Home health care agency Services (up to 100 visits per Calendar Year): No Charge
- Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency: No Charge

## OTHER

### Hospice Program Benefits
- Routine home care: No Charge
- Inpatient Respite Care: No Charge
- 24-hour Continuous Home Care: No Charge
- General Inpatient Care: No Charge

### Chiropractic Benefits
- Chiropractic Services (up to 20 visits per Calendar Year): No Charge
- Acupuncture Benefits
- Acupuncture Services (up to 12 visits per Calendar Year): No Charge

### Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)
- Office location: No Charge
- Speech Therapy Benefits
- Office Visit: No Charge

### Pregnancy and Maternity Care Benefits
- Prenatal and postnatal Physician office visits: $30 per visit
- Abortion services (Facility charges may apply - see *Hospital Benefits (Facility Services)*): No Charge

### Family Planning Benefits
- Counseling and consulting: No Charge
- Tubal ligation: No Charge
- Vasectomy: No Charge

### Diabetes Care Benefits
- Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits): No Charge
- Diabetes self-management training: $30 per visit

### Hearing Aid Benefits
- Audiological evaluations: $30 per visit
- 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

### Care Outside of Plan Service Area
- Benefits provided through BlueCard® Program, for out-of-state emergency and non-emergency care, are provided at the Participating level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.
- Within US: BlueCard Program
- Outside of US: BlueCard Worldwide
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 above the allowable amount do not count toward the Calendar Year deductible or out-of-pocket maximum.

Copayments/Coinsurance marked with this footnote do 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.

Participating non Hospital based ("freestanding") laboratory or radiology centers may not be available in all areas. Laboratory and radiology Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient surgery Services may also be obtained from a Hospital or from an ambulatory surgery center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

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.

Bariatric surgery is covered when pre-authorized by the Plan. 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 the Plan, 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 benefit details.

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.

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 plan medical deductible has been met.

Services may require prior authorization by the Plan. When services are prior authorized, members pay the Participating provider amount.

Mental health and Substance Abuse services are accessed through Blue Shield’s Participating and Non Participating providers.

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 covered through Blue Shield using Blue Shield's Participating providers or with Non Participating providers.

Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Participating provider copayment.

Includes insertion of IUD, as well as injectable and implantable contraceptives for women.

Copayment shown is for physician’s services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply. Services from Non Participating providers and Non Participating facilities are not covered under this benefit.

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.

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

ASO (1/15) RH 042815; DC 050715; 052615; 060415
Self-Insured Schools of California (SISC)
Pharmacy Benefit Schedule

<table>
<thead>
<tr>
<th>PLAN</th>
<th>200DED/10-35</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Walk-in</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>Days’ Supply*</td>
<td>30</td>
</tr>
<tr>
<td>Generic</td>
<td>$10</td>
</tr>
<tr>
<td>Brand</td>
<td>$35</td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
</tr>
<tr>
<td>Brand/Specialty Deductible</td>
<td>$200</td>
</tr>
</tbody>
</table>

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.

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.
### Benefit Summary

**SISC Custom HMO 25-500 Admit Inpatient**

(Uniform Health Plan Benefits and Coverage Matrix)

**Blue Shield of California**

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

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### Effective: October 1, 2015

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Medical Deductible</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Calendar Year Out-of-Pocket Maximum</strong></td>
<td>$2,000 per Individual / $4,000 per Family</td>
</tr>
<tr>
<td><strong>LIFETIME BENEFIT MAXIMUM</strong></td>
<td>None</td>
</tr>
</tbody>
</table>

**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)
- Outpatient X-ray, pathology and laboratory
  - No Charge

**Allergy Testing and Treatment Benefits**

- Office visits (includes visits for allergy serum injections)
  - $25 per visit

**Access+ Specialist Benefits**

- 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 SERVICES**

**Hospital Benefits (Facility Services)**

- Outpatient surgery performed at an Ambulatory Surgery Center
  - $150 per surgery
- Outpatient surgery in a hospital
  - $300 per surgery
- Outpatient Services for treatment of illness or injury and necessary supplies
  - 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 Medically Necessary skilled nursing Services including Subacute Care
  - $100 per day

**EMERGENCY HEALTH COVERAGE**

- Emergency room Services not resulting in admission (The ER 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
  - $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 copay may apply)
  - No Charge
- Orthotic equipment and devices (Separate office visit copay 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 SERVICES

- 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 and transcranial magnetic stimulation. For partial hospitalization programs, a higher copayment and facility charges may apply per episode of care): No Charge

### HOME HEALTH SERVICES

- Home health care agency Services (up to 100 visits per Calendar Year): $25 per visit
- Medical supplies (See "Prescription Drug Coverage" for specialty drugs): No Charge

### OTHER

#### Hospice Program Benefits
- Routine home care: No Charge
- Inpatient Respite Care: No Charge
- 24-hour Continuous Home Care: $250 per day
- General Inpatient care: $250 per day

#### Pregnancy and Maternity Care Benefits
- Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services"): No Charge
- Abortion services\(^7\): $100 per surgery

#### Family Planning and Infertility Benefits
- Counseling and consulting\(^7\): No Charge
- Infertility Services (member 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\(^8\): $75 per surgery

#### Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)

**Office Location (Copayment applies to all places of services, including professional and facility settings)**: $25 per visit

#### Speech Therapy Benefits

**Office Visit (Copayment applies to all places of services, including professional and facility settings)**: $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 Aids

- 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 (BlueCard\(^8\) Program)

- Urgent Services outside your Personal Physician Service Area: $25 per visit

### Optional Benefits

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

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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. Access+ Specialist visits for mental health services must be provided by a MHSA network Participating provider.
2. Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient surgery Services may also be obtained from a Hospital or from an ambulatory surgery center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.
3. 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.
4. Skilled nursing services are limited to 100 preauthorized days during a calendar year except when received through a hospice program provided by a Participating hospice agency. This 100 preauthorized day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.
5. Mental Health and Substance Abuse services are accessed through Blue Shield’s Mental Health Service Administrator (MHSA) using Blue Shield’s MHSA Participating providers.
6. 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.
7. Includes insertion of IUD, as well as injectable and implantable contraceptives for women.
8. Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

Plan designs may be modified to ensure compliance with state and federal requirements.
Chiropractic and Acupuncture Benefits
Additional coverage for your HMO and POS plans

Blue Shield Chiropractic and Acupuncture Care coverage lets you self-refer to a network of more than 3,310 licensed chiropractors and more than 1,245 licensed acupuncturists. Benefits are provided through a contract with American Specialty Health Plans of California, Inc. (ASH Plans).

How the Program Works
You can visit any participating chiropractors or acupuncturists in California from the ASH Plans network without a referral from your HMO or POS Personal Physician. Simply call a participating provider to schedule an initial exam.

At the time of your first visit, you’ll present your Blue Shield identification card and pay only your copayment. Because participating chiropractors and acupuncturists bill ASH Plans directly, you’ll never have to file claim forms.

If you need further treatment, the participating chiropractor or acupuncturist will submit a proposed treatment plan to ASH Plans and obtain the necessary authorization from ASH Plans to continue treatment up to the calendar-year maximum of 30 combined visits.

What’s Covered
The plan covers medically necessary chiropractic and acupuncture services including:

- Initial and subsequent examinations
- Office visits and adjustments (subject to annual limits)
- Adjunctive therapies
- X-rays (chiropractic only)

Benefit Plan Design

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture Services</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$10 per visit</td>
</tr>
</tbody>
</table>

Out-of-network Coverage: None

1. Chiropractic appliances are covered up to a maximum of $50 in a calendar-year as authorized by ASH Plans.
2. As authorized by ASH Plans, this allowance is applied toward the purchase of items determined necessary, such as supports, collars, pillows, heel lifts, ice packs, cushions, orthotics, rib belts and home traction units.

Friendly Customer Service
Helpful ASH Plans Member Services representatives are available at (800) 678-9133 Monday through Friday from 6 a.m. to 5 p.m. to answer questions, assist with problems, or help locate a participating chiropractor or acupuncturist.

This document is only a summary for informational purposes. It is not a contract. Please refer to the Evidence of Coverage and the Group Health Service Agreement for the exact terms and conditions of coverage.
# Self-Insured Schools of California (SISC) Pharmacy Benefit Schedule

<table>
<thead>
<tr>
<th>PLAN</th>
<th>200DED/10-35</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Walk-in</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>Days’ Supply*</td>
<td>30</td>
</tr>
<tr>
<td>Generic</td>
<td>$10</td>
</tr>
<tr>
<td>Brand</td>
<td>$35</td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$2,500 Individual / $3,500 Family</td>
</tr>
<tr>
<td>Brand/Specialty Deductible</td>
<td>$200 Individual / $500 Family</td>
</tr>
</tbody>
</table>

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**.

Navi-Gate® for Members allows you to access personalized pharmacy benefit information online at [www.navitus.com](http://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.
### Benefit Summary

**Blue Shield of California**

**Highlights:**  
- $1,500 individual coverage deductible or $3,000 family coverage deductible

**Effective:** October 1, 2015

<table>
<thead>
<tr>
<th><strong>Calendar Year Deductible</strong></th>
<th><strong>Participating Providers</strong></th>
<th><strong>Non Participating Providers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(All providers combined)</td>
<td>$1,500 per Individual / $3,000 per Family</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Calendar Year Out-of-Pocket Maximum</strong></th>
<th><strong>Participating Providers</strong></th>
<th><strong>Non Participating Providers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Includes the plan deductible)</td>
<td>$4,000 per Individual / $8,000 per Family</td>
<td></td>
</tr>
</tbody>
</table>

**LIFETIME BENEFIT MAXIMUM**

**Covered Services**

**Member Copayment**

### Professional Services

#### Physician & Specialist Office Visits
- **Participating Providers:** 10%  
- **Non Participating Providers:** 50%

#### CT Scans, MRIs, MRAs, PET Scans, and Cardiac Diagnostic Procedures
- **Participating Providers:** 10%  
- **Non Participating Providers:** 50%

#### Other outpatient X-ray, pathology and laboratory services (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)
- **Participating Providers:** 10%  
- **Non Participating Providers:** Not Covered

### Allergy Testing and Treatment Benefits

- **Office visits (includes visits for allergy serum injections)**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** 50%

### Preventive Health Benefits

- **Preventive Health Services (As required by applicable federal law.)**
  - **Participating Providers:** No Charge  
  - **Non Participating Providers:** Not Covered

### Outpatient Services

#### Hospital Benefits (Facility Services)

- **Outpatient surgery performed at an Ambulatory Surgery Center**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** No Charge

- **Outpatient surgery in a hospital**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** 50%

- **Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under “Rehabilitation Benefits”)**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** 50%

- **CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** 50%

- **Other outpatient X-ray, pathology and laboratory performed in a hospital**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** Not Covered

#### Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)
- **Participating Providers:** 10%  
- **Non Participating Providers:** No Charge

### Hospitalization Services

#### Hospital Benefits (Facility Services)

- **Inpatient Physician Services**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** 50%

- **Inpatient Non-emergency Facility Services (Semi-private room and board, and medically necessary Services and supplies, including Subacute Care)**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** No Charge

- **Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** No Charge

### Skilled Nursing Facility Benefits (Combined maximum of up to 100 days per Calendar Year; semi-private accommodations)

- **Services by a free-standing Skilled Nursing Facility**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** 10%

- **Skilled Nursing Unit of a Hospital**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** No Charge

### Emergency Health Coverage

- **Emergency room Services not resulting in admission (The ER copayment does not apply if the member is directly admitted to the hospital for inpatient services)**
  - **Participating Providers:** $100 per visit + 10%  
  - **Non Participating Providers:** $100 per visit + 10%

- **Emergency room Services resulting in admission (when the member is admitted directly from the ER)**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** 10%

- **Emergency room Physician Services**
  - **Participating Providers:** 10%  
  - **Non Participating Providers:** 10%

---

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.
## AMBULANCE SERVICES
- Emergency or authorized transport: 10% 10%

## PRESCRIPTION DRUG COVERAGE\(^{11, 12, 13, 14, 15}\)

*(Subject to deductible)*

### Outpatient Prescription Drug Benefits

#### Retail Prescriptions  (For up to a 30-day supply)

- Contraceptive Drugs and Devices\(^{16}\): No Charge  Not Covered
- Formulary Generic Drugs: $7 per prescription  $7 per prescription
- Formulary Brand Name Drugs: $25 per prescription  $25 per prescription
- Non-Formulary Brand Name Drugs: $25 per prescription  $25 per prescription

### Mail Service Prescriptions (For up to a 90-day supply)

- Contraceptive Drugs and Devices\(^{16}\): No Charge  Not Covered
- Formulary Generic Drugs: $14 per prescription  Not Covered
- Formulary Brand Name Drugs: $60 per prescription  Not Covered
- Non-Formulary Brand Name Drugs: $60 per prescription  Not Covered

### Specialty Pharmacies (up to a 30-day supply)

- Specialty Drugs: $25 per prescription  Not Covered

## PROSTHETICS/ORTHOTICS

- Prosthetic equipment and devices: 10% 50%\(^2\)
- Orthotic equipment and devices: 10%  Not Covered

## DURABLE MEDICAL EQUIPMENT

- Breast pump: No Charge  Not Covered
- Other Durable Medical Equipment: 10%  Not Covered

## MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES\(^{17, 18}\)

- Inpatient Hospital Services: 10%  No Charge\(^7\)
- Residential Care: 10%  No Charge\(^7\)
- 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 programs, and transcranial magnetic stimulation. For partial hospitalization programs, a higher copayment and facility charges may apply per episode of care): 10%  50%\(^2\)

## HOME HEALTH SERVICES

- Home health care agency Services (up to 100 visits per Calendar Year): 10%  Not Covered\(^{19}\)
- Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency: 10%  Not Covered\(^{19}\)

## OTHER

### Hospice Program Benefits

- Routine home care: 10%  Not Covered\(^{19}\)
- Inpatient Respite Care: 10%  Not Covered\(^{19}\)
- 24-hour Continuous Home Care: 10%  Not Covered\(^{19}\)
- General Inpatient care: 10%  Not Covered\(^{19}\)

### Chiropractic Benefits\(^8\)

- Chiropractic Services (up to 20 visits per Calendar Year): 10%  Not Covered

### Acupuncture Benefits\(^8\)

- Acupuncture Services (up to 12 visits per Calendar Year): 10%  50%\(^2\)

### Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)

- Office location: 10%  Not Covered

### Speech Therapy Benefits

- Office Visit: 10%  50%\(^2\)

### Pregnancy and Maternity Care Benefits

- Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services"): 10%  50%\(^2\)
- Abortion services (Facility charges may apply - see "Hospital Benefits (Facility Services)\(^{11}\)"
Family Planning Benefits

- Counseling and consulting\(^2\) [No Charge]
  (Not subject to the Calendar Year Deductible)
- Tubal ligation [No Charge]
  (Not subject to the Calendar Year Deductible)
- Vasectomy\(^2\) [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 Aid Benefits
  - Audiological evaluations [10%]
  50%\(^2\)
  - 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) [10%]
  10%

Care Outside of Plan Service Area (Benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the participating level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)

- Within US: BlueCard Program
  See Applicable Benefit
- Outside of US: BlueCard Worldwide
  See Applicable Benefit

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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. Participating non-Hospital based (“freestanding”) laboratory or radiology centers may not be available in all areas. Laboratory and radiology Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital, and paid according to the benefit under your health plan’s Hospital Benefits.

4. Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient surgery Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital, and paid according to the benefit under your health plan’s Hospital Benefits.

5. 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.

6. Bariatric surgery is covered when pre-authorized by the Plan. 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 the Plan, 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 benefit details.

7. The maximum allowed charge 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. Payments that exceed the allowed charge do not count toward the Calendar Year out-of-pocket maximum, and continue to be owed after the maximum is reached.

8. For plans with a Calendar Year 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.

9. Services may require prior authorization by the Plan. When services are prior authorized, members pay the Participating provider amount.

10. 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.

11. If the member requests a Brand Name drug when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the Brand Name Drug and its generic drug equivalent, as well as the applicable generic drug Copayment. This difference in cost that the member must pay is not applied to their Calendar Year deductible and is not included in the Calendar Year out-of-pocket maximum responsibility calculations.

12. 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.

13. For the Outpatient Prescription Drugs Benefit, covered Drugs obtained from Non Participating Pharmacies will be subject to and accrue to the Calendar Year Deductible and the Calendar Year Out-of-Pocket Maximum for Participating providers.

14. Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.

15. Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneous or intramuscularly), by inhalation, orally or by topical. Specialty Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield’s Pharmacy & Therapeutics Committee. Infused or Intravenous (IV) medications are not included as Specialty Drugs.

16. Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will not be subject to the Calendar Year deductible. If a Brand Name contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield for the Brand Name contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.

17. Mental Health and Substance Abuse services are accessed through Blue Shield’s Participating and Non Participating providers.

18. Outpatient 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 with Non Participating providers.

19. Services from Non Participating providers and Non Participating facilities are not covered under this benefit.

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

ASO (1/15) DC 051215; 052615; 060415; 061815
SISC KAISER PERMANENTE

HEALTH PLANS

SISC KAISER PERMANENTE HMO HEALTH PLAN

✈

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

600115 SISC - SELF-INSURED SCHOOLS OF CALIFORNIA

Principal Benefits for
Kaiser Permanente Traditional Plan (10/1/15—9/30/16)

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 Northern 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 1/1/15 through 12/31/15 (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)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Primary Care Visits for evaluations and treatment</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Most Specialty Care Visits for consultations, evaluations, and treatment</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Routine physical maintenance exams, including well-woman exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Well-child preventive exams (through age 23 months)</td>
<td>No charge</td>
</tr>
<tr>
<td>Family planning counseling and consultations</td>
<td>No charge</td>
</tr>
<tr>
<td>Scheduled prenatal care exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Routine eye exams with a Plan Optometrist</td>
<td>No charge</td>
</tr>
<tr>
<td>Hearing exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Urgent care consultations, evaluations, and treatment</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Most physical, occupational, and speech therapy</td>
<td>$25 per visit</td>
</tr>
</tbody>
</table>

Outpatient Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery and certain other outpatient procedures</td>
<td>$25 per procedure</td>
</tr>
<tr>
<td>Allergy injections (including allergy serum)</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Most immunizations (including the vaccine)</td>
<td>No charge</td>
</tr>
<tr>
<td>Most X-rays and laboratory tests</td>
<td>No charge</td>
</tr>
<tr>
<td>Covered individual health education counseling</td>
<td>No charge</td>
</tr>
<tr>
<td>Covered health education programs</td>
<td>No charge</td>
</tr>
</tbody>
</table>

Hospitalization Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs</td>
<td>No charge</td>
</tr>
</tbody>
</table>

Emergency Health Coverage

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department visits</td>
<td>$100 per visit</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>$50 per trip</td>
</tr>
</tbody>
</table>

Prescription Drug Coverage

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered outpatient items in accord with our drug formulary guidelines at a Plan Pharmacy or through our mail-order service:</td>
<td></td>
</tr>
<tr>
<td>Most generic items</td>
<td>$10 for up to a 100-day supply</td>
</tr>
<tr>
<td>Most brand-name items</td>
<td>$25 for up to a 100-day supply</td>
</tr>
</tbody>
</table>

Durable Medical Equipment (DME)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>DME items that are essential health benefits in accord with our DME formulary guidelines</td>
<td>No charge</td>
</tr>
<tr>
<td>DME items that are not essential health benefits in accord with our DME formulary guidelines</td>
<td>No charge</td>
</tr>
</tbody>
</table>

4181294.33.2.S000424707 - SISC - Self-Insured Schools Of California (continues)
### Benefit Summary

#### Mental Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient psychiatric hospitalization</td>
<td>No charge</td>
</tr>
<tr>
<td>Individual outpatient mental health evaluation and treatment</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Group outpatient mental health treatment</td>
<td>$12 per visit</td>
</tr>
</tbody>
</table>

#### Chemical Dependency Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient detoxification</td>
<td>No charge</td>
</tr>
<tr>
<td>Individual outpatient chemical dependency evaluation and treatment</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Group outpatient chemical dependency treatment</td>
<td>$5 per visit</td>
</tr>
</tbody>
</table>

#### Home Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care (up to 100 visits per calendar year)</td>
<td>No charge</td>
</tr>
</tbody>
</table>

#### Other

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility care (up to 100 days per benefit period)</td>
<td>No charge</td>
</tr>
<tr>
<td>Prosthetic and orthotic devices</td>
<td>No charge</td>
</tr>
<tr>
<td>All Services related to covered infertility treatment</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Hospice care</td>
<td>No charge</td>
</tr>
</tbody>
</table>

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).
Your Kaiser Permanente CHIROPRACTIC and ACUPUNCTURE benefits

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

1. Find an ASH Plans Participating Chiropractor or Participating Acupuncturist near you.
   - 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.)
YOUR KAISER PERMANENTE COMBINED CHIROPRACTIC AND ACUPUNCTURE BENEFIT

<table>
<thead>
<tr>
<th>Services</th>
<th>Cost Sharing and Office Visit Maximums</th>
</tr>
</thead>
</table>
| Chiropractic Services are covered when a Participating Chiropractor finds that the Services are Medically Necessary to treat or diagnose Neuromusculoskeletal Disorders. Acupuncture Services are covered when a Participating Acupuncturist 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 Chiropractors and Participating Acupuncturists 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 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 any applicable deductible or 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 Chiropractors and Participating Acupuncturists except for Emergency Chiropractic and Acupuncture Services, and Services that are not available from Participating Providers. Each office visit counts toward the year visit limit 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 a Participating Chiropractor provides the Services or refers you to a Participating Provider for the Services.

<table>
<thead>
<tr>
<th>Participating Chiropractors and Acupuncturists</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ASH Plans contracts with Participating Chiropractors and other Participating Providers to provide covered Chiropractic Services (including laboratory tests, X-rays, and chiropractic appliances). ASH Plans contracts with Participating Acupuncturists to provide acupuncture care (including adjunctive therapies, such as acupressure, cupping, 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, except for Emergency Chiropractic and Acupuncture Services, Urgent Chiropractic and Acupuncture Services, and Services that are not available from Participating Providers that are authorized in advance by ASH Plans. The list of Participating Chiropractors and Acupuncturists is available from the ASH Plans Member Services Department at 1-800-678-9133. The list of Participating Chiropractors and Acupuncturists is subject to change at any time without notice.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>How to Obtain Covered Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To obtain covered Services, call a Participating Chiropractor or Participating Acupuncturist to schedule an initial examination. If additional Services are required, verification that the Services are Medically Necessary may be required. Your Participating Chiropractor or Acupuncturist will request any required approvals. An ASH Plan’s clinician in the same or similar specialty as the provider of Chiropractic or Acupuncture Services under review will decide whether Chiropractic or Acupuncture 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 Member Services Department.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Second Opinions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>You may request a second opinion in regard to covered Services by contacting another Participating Chiropractor or Acupuncturist. A Participating Chiropractor or Acupuncturist may also request a second opinion in regard to covered Services by referring you to another Participating Chiropractor or Acupuncturist in the same or similar specialty.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your Costs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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 out-of-pocket maximum described in the Health Plan Evidence of Coverage (unless you have a plan with an HSA option).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency and Urgent Chiropractic Services/Emergency and Urgent Acupuncture Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Emergency Chiropractic Services are those emergency services provided for treatment of Neuromusculoskeletal Disorder, nausea, or pain. Covered Acupuncture Services are those emergency services provided for treatment of Neuromusculoskeletal Disorder, nausea, or pain. These conditions must manifest themselves by acute symptoms of sufficient severity, including severe pain, such that a reasonable person could expect the absence of immediate Chiropractic or Acupuncture Services to result in serious jeopardy to your health or body functions or organs. Covered Urgent Chiropractic Services and Acupuncture Services consist of Chiropractic Services and Acupuncture Services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the Service Area.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Getting Assistance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have questions about the Services you can get from an ASH Plans Participating Provider, you may call ASH Plans Member Services at 1-800-678-9133 (TTY users call 711), weekdays from 5 a.m. to 6 p.m. Pacific time.</td>
<td></td>
</tr>
</tbody>
</table>
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, or similar devices or appliances
- 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.

**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 Acupuncturist**: 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. A list of Participating Acupuncturists is available from the ASH Plans Member Services Department toll free at 1-800-678-9133 (TTY users call 711). The list of Participating Acupuncturists is subject to change at any time, without notice. If you have questions, please call the ASH Plans Member Services Department.

**Participating Chiropractor**: 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. A list of Participating Chiropractors is available from the ASH Plans Member Services Department at 1-800-678-9133 (TTY users call 711). The list of Participating Chiropractors is subject to change at any time, without notice. If you have questions, please call the ASH Plans Member Services Department.

**Participating Provider**: A Participating Chiropractor, Participating Acupuncturist, or any licensed provider with which ASH Plans contracts to provide covered care, including laboratory tests or X-rays that are covered chiropractic care.
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 Chiropractors and Participating Acupuncturists available to you. You can obtain covered Services from any Participating Chiropractor or Participating Acupuncturist 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.
Proposed Benefit Summary

SISC-SELF INSURED SCHOOLS OF CALIFORNIA

Principal Benefits for
Kaiser Permanente HSA-Qualified Deductible HMO Plan (10/1/15—9/30/16)

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

1. The Services are Medically Necessary
2. The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the Evidence of Coverage (EOC) for authorized referrals, 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.

Accumulation Period

The Accumulation Period for this plan is 1/1/15 through 12/31/15 (calendar year).

Out-of-Pocket Maximum

You will not pay any more Cost Share during 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) $6,000 per calendar year
- For an entire Family of two or more Members $12,000 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.

Lifetime Maximum

<table>
<thead>
<tr>
<th>Professional Services (Plan Provider office visits)</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Primary Care Visits for evaluations and treatment</td>
<td>10% Coinsurance after Plan Deductible</td>
</tr>
<tr>
<td>Most Specialty Care Visits for consultations, evaluations, and treatment</td>
<td>10% Coinsurance after Plan Deductible</td>
</tr>
<tr>
<td>Routine physical maintenance exams, including well-woman exams</td>
<td>No charge (Plan Deductible doesn't apply)</td>
</tr>
<tr>
<td>Well-child preventive exams (through age 23 months)</td>
<td>No charge (Plan Deductible doesn't apply)</td>
</tr>
<tr>
<td>Family planning counseling and consultations</td>
<td>No charge (Plan Deductible doesn't apply)</td>
</tr>
<tr>
<td>Scheduled prenatal care exams</td>
<td>No charge (Plan Deductible doesn't apply)</td>
</tr>
<tr>
<td>Routine eye exams with a Plan Optometrist for Members under age 19</td>
<td>10% Coinsurance after Plan Deductible</td>
</tr>
<tr>
<td>Routine eye exams with a Plan Optometrist for Members age 19 and older</td>
<td>10% Coinsurance after Plan Deductible</td>
</tr>
<tr>
<td>Hearing exams</td>
<td>No charge (Plan Deductible doesn't apply)</td>
</tr>
<tr>
<td>Urgent care consultations, evaluations, and treatment</td>
<td>10% Coinsurance after Plan Deductible</td>
</tr>
<tr>
<td>Most physical, occupational, and speech therapy</td>
<td>10% Coinsurance after Plan Deductible</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Hospitalization Services</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs</td>
<td>10% Coinsurance after Plan Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Health Coverage</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department visits</td>
<td>10% Coinsurance after Plan Deductible</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Ambulance Services</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>10% Coinsurance after Plan Deductible</td>
</tr>
</tbody>
</table>

(continues)
### Prescription Drug Coverage

<table>
<thead>
<tr>
<th>Covered outpatient items in accord with our drug formulary guidelines:</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most generic items at a Plan Pharmacy</td>
<td>$10 for up to a 30-day supply after Plan Deductible</td>
</tr>
<tr>
<td>Most generic refills through our mail-order service</td>
<td>$20 for up to a 100-day supply after Plan Deductible</td>
</tr>
<tr>
<td>Most brand-name items at a Plan Pharmacy</td>
<td>$30 for up to a 30-day supply after Plan Deductible</td>
</tr>
<tr>
<td>Most brand-name refills through our mail-order service</td>
<td>$60 for up to a 100-day supply after Plan Deductible</td>
</tr>
</tbody>
</table>

### Durable Medical Equipment (DME)

<table>
<thead>
<tr>
<th>DME items that are essential health benefits in accord with our DME formulary guidelines</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>10% Coinsurance after Plan Deductible</td>
</tr>
</tbody>
</table>

### Mental Health Services

<table>
<thead>
<tr>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient psychiatric hospitalization</td>
</tr>
<tr>
<td>Individual outpatient mental health evaluation and treatment</td>
</tr>
<tr>
<td>Group outpatient mental health treatment</td>
</tr>
</tbody>
</table>

### Chemical Dependency Services

<table>
<thead>
<tr>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient detoxification</td>
</tr>
<tr>
<td>Individual outpatient chemical dependency evaluation and treatment</td>
</tr>
<tr>
<td>Group outpatient chemical dependency treatment</td>
</tr>
</tbody>
</table>

### Home Health Services

<table>
<thead>
<tr>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care (up to 100 visits per calendar year)</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility care (up to 100 days per benefit period)</td>
</tr>
<tr>
<td>Ostomy and urological supplies</td>
</tr>
<tr>
<td>Prosthetic and orthotic devices that are essential health benefits</td>
</tr>
<tr>
<td>Prosthetic and orthotic devices that are not essential health benefits</td>
</tr>
<tr>
<td>Hospice care</td>
</tr>
</tbody>
</table>

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).