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)

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.

Blue Shield of California

Effective: October 1, 2015

	Participating Providers[1]	Non Participating Providers[1]
Calendar Year Medical Deductible (All providers combined)	None	
Calendar Year Out-of-Pocket Maximum[2] (Includes the plan deductible)	$1,000 per individual / $3,000 per family	
LIFETIME BENEFIT MAXIMUM	None	
Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES	**Participating Providers[1]**	**Non Participating Providers[1]**
Professional (Physician) Benefits		
• Physician and specialist office visits	$30 per visit	50%[2]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)[3]	No Charge	50%[2]
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[3]	No Charge	Not Covered
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	No Charge	50%[2]
Preventive Health Benefits		
• Preventive Health Services (As required by applicable federal law.)	No Charge	Not Covered
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[4]	No Charge	No Charge[5]
• Outpatient surgery in a hospital	No Charge	No Charge[5]
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	No Charge	50%[2]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[3]	No Charge	50%[2, 5]
• Other outpatient X-ray, pathology and laboratory performed in a hospital[3]	No Charge	Not Covered
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	No Charge	No Charge[5]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	No Charge	50%[2, 15]
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	No Charge	No Charge[7]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	No Charge	No Charge[7]
Skilled Nursing Facility Benefits[8] (Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	No Charge	No Charge[9]
• Skilled Nursing Unit of a Hospital	No Charge	No Charge[7]
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	$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[15]

AMBULANCE SERVICES		
• Emergency or authorized transport	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 copay may apply)	No Charge	50%[2]
• Orthotic equipment and devices (Separate office visit copay 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[10, 11]		
• Inpatient Hospital Services	No Charge	No Charge[7]
• Residential Care	No Charge	No Charge[7]
• Inpatient Physician Services	No Charge	50%[2, 15]
• Routine Outpatient Mental Health and Substance Abuse Services (includes professional/physician visits)	$30 per visit	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)	No Charge	50%[2]
HOME HEALTH SERVICES		
• Home health care agency Services (up to 100 visits per Calendar Year)[8]	No Charge	Not Covered[12]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	No Charge	Not Covered[12]
OTHER		
Hospice Program Benefits		
• Routine home care	No Charge	Not Covered[12]
• Inpatient Respite Care	No Charge	Not Covered[12]
• 24-hour Continuous Home Care	No Charge	Not Covered[12]
• General Inpatient care	No Charge	Not Covered[12]
Chiropractic Benefits[8]		
• Chiropractic Services (up to 20 visits per Calendar Year)	No Charge	Not Covered
Acupuncture Benefits[8]		
• Acupuncture Services (up to 12 visits per Calendar Year)	No Charge	50%[2]
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
• Office location	No Charge	Not Covered
Speech Therapy Benefits		
• Office Visit	No Charge	50%[2]
Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services")	$30 per visit	50%[2]
• Abortion services (Facility charges may apply - see "Hospital Benefits (Facility Services)")	No Charge	Not Covered
Family Planning Benefits		
• Counseling and consulting[13]	No Charge	Not Covered
• Tubal ligation	No Charge	Not Covered
• Vasectomy[14]	No Charge	Not Covered
Diabetes Care Benefits		
• Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)	No Charge	50%[2]
• Diabetes self-management training	$30 per visit	50%[2]
Hearing Aid Benefits		
• Audiological evaluations	$30 per visit	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)	No Charge	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	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 above the allowable amount do not count toward the Calendar Year deductible or out-of-pocket maximum.

2 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.

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 an ambulatory surgery 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 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.

8 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.

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

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

11 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 with Non Participating providers.

12 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.

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

14 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.

15 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

PLAN	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

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.

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

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.

Blue Shield of California

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

Effective: October 1, 2015

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**
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 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[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 SERVICES	
Hospital Benefits (Facility Services)	
• Outpatient surgery performed at an Ambulatory Surgery Center[2]	$150 per surgery
• Outpatient surgery in a hospital	$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
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[3, 4]	$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[5, 6]	
• 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[8]	$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® 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.	

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.

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

Calendar-year Maximum	30 Combined Visits
Calendar-year Deductible	None
Calendar-year Chiropractic Appliances Benefit[1,2]	$50
Covered Services	**Member Copayment**
Acupuncture Services	$10 per visit
Chiropractic Services	$10 per visit
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

PLAN	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

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.

SISC
ASO PPO HSA Plan A
Benefit Summary

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.

Blue Shield of California

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

Effective: October 1, 2015

	Participating Providers[1]	Non Participating Providers[1]
Calendar Year Deductible (All providers combined) (Note: For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.)	$1,500 per Individual / $3,000 per Family	
Calendar Year Out-of-Pocket Maximum[2] (Includes the plan deductible) (For individual on family coverage plan, enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met.)	$4,000 per Individual / $8,000 per Family	
LIFETIME BENEFIT MAXIMUM	None	
Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES	**Participating Providers[1]**	**Non Participating Providers[1]**
Professional (Physician) Benefits		
• Physician and specialist office visits	10%	50%[2]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)[3]	10%	50%[2]
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[3]	10%	Not Covered
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	10%	50%[2]
Preventive Health Benefits		
• Preventive Health Services (As required by applicable federal law.)	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[4]	10%	No Charge[5]
• Outpatient surgery in a hospital	10%	No Charge[5]
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	10%	50%[2]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[3]	10%	50%[2, 5]
• Other outpatient X-ray, pathology and laboratory performed in a hospital[3]	10%	Not Covered
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	10%	No Charge[5]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	10%	50%[2, 10]
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically necessary Services and supplies, including Subacute Care)	10%	No Charge[7]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	10%	No Charge[7]
Skilled Nursing Facility Benefits[8] (Combined maximum of up to 100 days per Calendar Year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	10%	10%[9]
• Skilled Nursing Unit of a Hospital	10%	No Charge[7]
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 + 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%[11]

AMBULANCE SERVICES		
• Emergency or authorized transport	10%	10%
PRESCRIPTION DRUG COVERAGE[11, 12, 13, 14, 15] (Subject to deductible)	**Participating Pharmacy**	**Non Participating Pharmacy**
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 (Separate office visit copay may apply)	10%	50%[2]
• Orthotic equipment and devices (Separate office visit copay may apply)	10%	Not Covered
DURABLE MEDICAL EQUIPMENT		
• Breast pump	No Charge (Not subject to the Calendar Year Deductible)	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)[8]	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)")	10%	Not Covered

Family Planning Benefits		
• Counseling and consulting[20]	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
• Tubal ligation	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
• Vasectomy[21]	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	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 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 an ambulatory surgery 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 (subcutaneously or intramuscularly), by inhalation, orally or topically. 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, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield. 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 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 with Non Participating providers.

19 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.

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

21 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.

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

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)

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)	**You Pay**
Most Primary Care Visits for evaluations and treatment	$25 per visit
Most Specialty Care Visits for consultations, evaluations, and treatment	$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 that are essential health benefits in accord with our DME formulary guidelines	No charge
DME items that are not essential health benefits in accord with our DME formulary guidelines	No charge

Benefit Summary *(continued)*

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$25 per visit
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
All Services related to covered infertility treatment	50% Coinsurance
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 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.)

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 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.

Participating Chiropractors and Acupuncturists

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.

How to Obtain Covered Services

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 Chriopractic or Acupuncture Services under review will decide whether Chiropractic or Acupuncture Servies 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.

Second Opinions

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.

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 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 Services/Emergency and Urgent Acupuncture Services

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.

Getting Assistance

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.

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.

American Specialty Health Plans of California

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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:

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

Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits for evaluations and treatment	10% Coinsurance after Plan Deductible
Most Specialty Care Visits for consultations, evaluations, and treatment	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 for Members under age 19	10% Coinsurance after Plan Deductible
Routine eye exams with a Plan Optometrist for Members age 19 and older	10% Coinsurance after Plan Deductible
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

(continues)

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
Ostomy and urological supplies	No charge after Plan Deductible
Prosthetic and orthotic devices that are essential health benefits	No charge after Plan Deductible
Prosthetic and orthotic devices that are not essential health benefits	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).