Your summary of benefits

Anthem BlueCross

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Your Plan: SISC Minimum Value HSA Plan

Your Network: Prudent Buyer PPO

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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible for all providers (calendar year) *See notes section to understand how your deductible works. No last-quarter carry-over. Deductible applies to out-of-pocket maximum.*	$5,000 single / $10,000 family	
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. Member copays and coinsurance for Emergency medical care with a Non-Network PPO provider also apply to the In-Network PPO out-of-pocket maximums. See notes section for additional information regarding your out of pocket maximum.*	$6,350 single / $12,700 family	No limit single / No limit family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	30% coinsurance	See footnote 1
Specialist care visit	30% coinsurance	See footnote 1
Prenatal and Post-natal Care	30% coinsurance	See footnote 1
Other practitioner visits: Retail health clinic	30% coinsurance	See footnote 1
Chiropractor services	30% coinsurance	Not covered

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Acupuncture *Coverage for In-Network Provider and Non-Network Provider combined is limited to 12 visit limit per calendar year.*	30% coinsurance	50% of maximum allowed amount
Other services in an office:		
Allergy testing	30% coinsurance	See footnote 1
Chemo/radiation therapy	30% coinsurance	See footnote 1
Hemodialysis *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	30% coinsurance	All billed amounts exceeding $350/visit
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	30% coinsurance	See footnote 1
Diagnostic Services		
Lab:		
Office	30% coinsurance	Not covered
Freestanding Lab	30% coinsurance	Not covered
Outpatient Hospital	30% coinsurance	Not covered
X-ray:		
Office	30% coinsurance	Not covered
Freestanding Radiology Center	30% coinsurance	Not covered
Outpatient Hospital	30% coinsurance	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	30% coinsurance	All billed amounts exceeding $800/test
Freestanding Radiology Center *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	30% coinsurance	All billed amounts exceeding $800/test

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Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	30% coinsurance	All billed amounts exceeding $800/test
Emergency and Urgent Care (Hospital Based)		
Emergency room facility services *Copay waived if admitted as inpatient. This is for the hospital/facility charge only. The ER physician charge may be separate.*	$100 copay per admission, then 30% coinsurance	Covered as In-Network
Emergency room doctor and other services	30% coinsurance	Covered as In-Network
Ambulance (air and ground)	$100 copay per trip, then 30% coinsurance	Covered as In-Network for true emergency
Urgent Care (office setting)	30% coinsurance	See footnote 1
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	30% coinsurance	See footnote 1
Facility visit:		
Facility fees	30% coinsurance	50% of maximum allowed amount
Outpatient Surgery		
Facility fees:		
Hospital	30% coinsurance	50% of maximum allowed amount
Services and supplies for the following outpatient surgeries are subject to a benefit limit if performed in an outpatient hospital: o Arthroscopy limited to $4,500 per procedure o Cataract surgery limited to $2,000 per procedure o Colonoscopy limited to $1,500 per procedure o Upper GI Endoscopy limited to $1,000 per procedure o Upper GI Endoscopy with biopsy limited to $1,250 per procedure	30% coinsurance up to benefit limit	50% of maximum allowed amount
Freestanding Ambulatory Surgical Center	30% coinsurance	

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Coverage for Out-of-Network Provider is limited to $350 maximum per admission.		All billed amounts exceeding $350/admission
Doctor and other services	30% coinsurance	See footnote 1
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Coverage for Out-of-Network Provider is limited to $600 maximum per day for non-emergency admission.*	30% coinsurance	All billed amounts exceeding $600/day
Doctor and other services	30% coinsurance	0% coinsurance
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visit limit per calendar year. Coverage for Out-of-Network Provider is limited to $150 per day.*	30% coinsurance	All billed amounts exceeding $150/day. (See footnote 1)
Rehabilitation services (for example, physical/occupational therapy):		
Office	30% coinsurance	Not covered
Outpatient hospital	30% coinsurance	Not covered
Habilitation services	30% coinsurance	Not covered
Cardiac rehabilitation		
Office	30% coinsurance	Not covered
Outpatient hospital	30% coinsurance	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 day limit per calendar year. Coverage for Out-of-Network Provider is limited to $600 maximum per day.*	30% coinsurance	10% coinsurance. (See footnote 1)

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Hospice	0% coinsurance	See footnote 1
Durable Medical Equipment	30% coinsurance	Not covered
Prosthetic Devices *Therapeutic shoes and inserts for members with diabetes are limited to 2 pairs per calendar year.*	30% coinsurance	Not covered
Hearing Aids *Benefit is limited to $700 every 24 months.*	30% coinsurance	See footnote 1
Hip/Knee/Spine *For inpatient services, this benefit is covered only when performed at a designated Blue Distinction Plus Center for Specialty Care. Subject to utilization review.*	30% coinsurance	Not covered
Hemodialysis in an Outpatient facility *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	30% coinsurance	All billed amounts exceeding $350/visit
Home Infusion Therapy *Coverage for Out-of-Network Provider is limited to $600 maximum per day. Subject to utilization review.*	30% coinsurance	All billed amounts exceeding $600/day
Speech Therapy	30% coinsurance	See footnote 1

Footnote 1: When using Non-Network PPO Providers, members are responsible for any difference between the maximum allowed and actual charges, as well as any deductible & perce

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Notes:

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

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

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

PLAN RX 9-35 (MVP)

	Walk-In				Mail	
	Network		Costco		Costco	Navitus
Days' Supply*	30	90	30	90	90	30
Generic	$9	N/A	**FREE**	**FREE**	**FREE**	N/A
Brand	$35	N/A	$35	$90	$90	N/A
Specialty	N/A	N/A	N/A	N/A	N/A	$35

Out-of-Pocket Maximum	$6,350 Individual / $12,700 Family
Deductible**	$5,000 Individual / $10,000 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.

** Deductible applies to medical and pharmacy benefits. Free generics at Costco will only apply after deductible is satisfied.

Mail Order Service
The Mail Order Service allows you to receive a 90-day supply of maintenance medications. This program is part of your pharmacy benefit and is **voluntary**.

Specialty Pharmacy
Navitus SpecialtyRx helps members who are taking medications for certain chronic illnesses or complex diseases by providing services that offer convenience and support. This program is part of your pharmacy benefit and is **mandatory**.

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

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