SISC 2-Tier Anchor Bronze HSA Plan

In addition to dollar and percentage copays, Insured Persons are responsible for deductibles, as described below. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day regardless of whether your Deductible has been met. Please review the deductible information to know if a deductible applies to a specific covered service. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Subject to Utilization Review
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.

Explanation of Maximum Allowed Amount
Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non- Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

PPO Providers—The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-PPO Providers—For non-emergency care, reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount.

For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers
(*applicable to medical care & prescription drug benefits)*

> Single Insured Person	$5,000/Individual
> Family	$10,000/Family

> *No last quarter carry over*

Annual Out-of-Pocket Maximums *(including calendar year deductibles, copays, prescription drug covered expense)*
PPO Providers Only* $6,350/Individual/year; $12,700/Family/year

**Member copayments and coinsurance for Emergency Medical Care with a Non-PPO Provider also apply to the PPO Out-of-Pocket Maximums.*

The following do not apply to out-of-pocket maximums: Non-covered expenses and for non-PPO providers and Other Health Care Providers, amounts in excess of the covered expense.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay[1]
Hospital Medical Services *(Subject to Utilization Review for Inpatient services; waived for emergency admissions)*		
> Semi-private room, meals & special diets, & ancillary services	30%	0% (benefits limited to $600/day)
> Outpatient Hospital medical care, surgical services & supplies	30%	50%
> Services and supplies for the following outpatient surgeries are subject to a benefit limit if performed in an outpatient hospital:	30% up to benefit limit[3]	50%
• Arthroscopy limited to $4,500 per procedure		
• Cataract surgery limited to $2,000 per procedure		
• Colonoscopy limited to $1,500 per procedure		
• Upper GI Endoscopy limited to $1,000 per procedure		
• Upper GI Endoscopy with biopsy limited to $1,250 per procedure		
Ambulatory Surgical Centers		
> Outpatient surgery, services & supplies	30%	0% *(max. $350/admit)*
Hemodialysis		
> Outpatient hemodialysis services & supplies	30%	0% *(benefit limited to $350/visit)*
Skilled Nursing Facility *(Subject to Utilization Review)*		
> Semi-private room, services & supplies *(limited to 100 days per calendar year; limit does not apply to mental health and substance abuse)*	30%	10% *(benefit limited to $600/day)*
Hospice Care	0%	0%
> Inpatient or outpatient services; family bereavement services		

[1] When using Non-PPO Providers, members are responsible for any difference between the maximum allowed and actual charges, as well as any deductible & percentage copay.
[2] These providers are not represented in the PPO network.
[3] If you use an in-network outpatient hospital for services subject to the benefit limit, you'll be responsible for your regular deductible and co-insurance PLUS any amount over the maximum benefit, unless your provider receive advance certification that you need to be in an outpatient hospital setting.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay[1]
Home Health Care *(Subject to Utilization Review)* Services & supplies from a home health agency billed amounts exceeding $150/day. *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care)*	30%	All
Home Infusion Therapy *(Subject to Utilization Review)* > Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	30%	0% *(limited to $600/day)*
Physician Medical Services		
> Office Visit	30%	0%
> Hospital & skilled nursing facility visits	30%	0%
> Surgeon & surgical assistant; anesthesiologist or anesthetist	30%	0%
> Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	30%	0%
Diagnostic X-ray & Lab		
> MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	30%	0% *(benefit limited to $800/procedure)*
> Other diagnostic x-ray & lab	30%	Not covered
Physical Exams for Members (Adults & Children- all ages)		
> Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam	0% No co-pay *(deductible waived)*	Not covered
Adult Preventive Services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	0% *(deductible waived)*	Not covered
Physical Therapy, Physical Medicine, & Occupational Therapy, including Chiropractic Services	30%	Not covered
Speech Therapy		
> Outpatient speech therapy	30%	0%
Acupuncture		
> Services for the treatment of disease, illness or injury (limited to 12 visits/calendar year)	30%	50% of maximum allowed amount
Services for the treatment of Temporomandibular Joint Disorder (TMJ)		
> Splint Therapy and Surgical Treatment	30%	0%
Pregnancy & Maternity Care *(services cover subscriber, spouse & dependent daughters)*		
> Normal delivery, cesarean section, complications of pregnancy & abortion including pre- and post-natal care	30%	0%
> Inpatient physician services	30%	0%
> Hospital & ancillary services	30%	0%

[1] When using Non-PPO Providers, members are responsible for any difference between the maximum allowed and actual charges, as well as any deductible & percentage copay.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] and Blue Distinction Centers for Specialty Care [BDCSC] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*		
> Inpatient services provided in connection with non-investigative organ or tissue transplants	30%	Not covered
> Transplant travel expense for an authorized, specified transplant at a *CME (recipient & companion transportation limited to $10,000 per transplant)*	No copay *(deductible waived)*	Not covered
> Unrelated donor search, limited to $30,000 per transplant		
Bariatric Surgery *(subject to utilization review; covered only when performed at a designated Blue Distinction Center for Specialty Care – Bariatric Surgery)*		
o Acute care hospital (inpatient or outpatient) and Ambulatory Surgery Center services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	30%	Not covered
o Travel expenses when member's home is 50 miles or more from the nearest designated Blue Distinction Center for Specialty Care	No copay (*deductible waived)*	Not covered
o Bariatric Surgery *($3,000 maximum travel benefit per surgery)*		
Hip/Knee/Spine *(subject to utilization review; covered only when performed at a designated Blue Distinction Plus Center for Specialty Care)*		
o Inpatient services provided in connection with medically necessary surgery for hip/knee/spine	30%	Not covered
o Travel expenses when member's home is 50 miles or more from the nearest hip/knee/spine Blue Distinction Plus Center (*$6,000 maximum travel benefit)*	No copay *(deductible waived)*	Not covered
Diabetes Education Programs *(requires physician supervision)* Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	30%	0%
Prosthetic Devices		
> Coverage for breast prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; & the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes (2 pairs each/calendar year)	30%	Not covered
Durable Medical Equipment		
> Rental or purchase of DME , dialysis equipment & supplies, & therapeutic shoes & inserts for insured persons with diabetes	30%	Not covered
> Hearing Aid supplies and equipment (limited to $700 per 24 months)	30%	0%
Related Outpatient Medical Services & Supplies[2]		
> Ground or air ambulance transportation, services & disposable supplies *(air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to $50,000 for non-PPO)*	30%[2]	After a $100 copay
> Blood transfusions, blood processing & the cost of unreplaced blood & blood products	30%[2]	
> Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	30%[2]	

[1] When using Non-PPO Providers, members are responsible for any difference between the maximum allowed an actual charges, as well as any deductible & percentage copay.

[2] These providers are not represented in the PPO network.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay[1]
Emergency Care		
> Emergency room services & supplies *($100 co-pay waived if admitted)*	30% after $100 co-pay	0% after $100 co-pay
> Inpatient hospital services & supplies	30%	30% first 48 hours; 0% limited to $600/day after 48 hours (unless member cannot be moved safely)
> Physician services	30%	30%[2]
Mental or Nervous Disorders and Substance Abuse		
> Inpatient facility care *(subject to utilization review; waived for emergency admissions)*	30%	0% *(benefit limited to $600/day)*
> Inpatient physician visits	30%	0%
> Outpatient facility care	30%	50%
> Physician office visits	30%	0%

1 The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

2 The allowable rate for emergency within 48 hours is based on a reasonable charge, not the scheduled amount.

Medical Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.
Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).
Incarceration. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.
Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.
Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.
Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.
Family Members. Services prescribed, ordered, referred by or given by a member of your immediate family, including your *spouse*, *child*, brother, sister, parent, in-law or self .
Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.
Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
Mental Health Conditions. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.
Orthodontia. Braces, other orthodontic appliances or orthodontic services.
Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment
to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.
Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the EOC.
Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.
Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.
Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.
Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.
This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.
Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).
Sterilization Reversal.
Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.
In-vitro Fertilization. Services or supplies for in-vitro fertilization (IVF) for purposes of pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment.
Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
Foot Orthotics. Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
Air Conditioners. Air purifiers, air conditioners or humidifiers.
Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.
Health Club Memberships. Health club memberships, exercise equipment, charges from a physical
fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.
Personal Items. Any supplies for comfort, hygiene or beautification.
Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa. Additionally, this exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.
Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.
Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.
Routine Physicals and Immunizations. Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law as specified in the EOC.
Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.
Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.
Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.
Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.
Drugs Given to you by a Medical Provider. The following exclusions apply to drugs you receive from a medical provider:

- Delivery Charges. Charges for the delivery of prescription drugs.
- Clinically-Equivalent Alternatives. Certain prescription drugs may not be covered if you could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that for most members, will give you similar results for a disease or condition. If you have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

  If you or your physician believes you need to use a different prescription drug, please have your physician or pharmacist get in touch with us. We will cover the other prescription drug only if we agree that it is medically necessary and appropriate over the clinically equivalent drug. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.
- Drugs Contrary to Approved Medical and Professional Standards. Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the plan or us.
- Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity prescribed or for any refill given more than one year after the date of the original prescription.
- Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications. Prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.
- Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a physician.
- Lost or Stolen Drugs. Refills of lost or stolen drugs.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan.Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent Licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.
Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.
Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.
Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.
Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.
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Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.
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 coverages do not exceed 100% of the covered expense.

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

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.