

# Your summary of benefits



Anthem® Blue Cross Life and Health Insurance Company

Your Plan: SISC (Self Insured Schools of California): 90-D \$10 Anthem Classic PPO

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$200 person / \$500 family	
<b>Overall Out-of-Pocket Limit</b>	\$1,000 person / \$3,000 family	No limit person / No limit family
<p>The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>In-network and out-of-network deductibles are combined and accumulate toward each other; however, in-network and out-of-network out-of-pocket maximum amounts accumulate separately and do not accumulate toward each other.</p> <p>*For services received from an out-of-network provider, the member may be held responsible for any costs beyond the permitted amount and the overall charges.</p>		
<p><b>Doctor Visits (virtual and office)</b> <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p><b>Medical Chats and Virtual Visits for Primary Care</b> <i>from our Online Provider K Health, through its affiliated Provider groups are covered at No Charge.</i></p>		
<p><b>Virtual Visits from online provider LiveHealth Online</b> <i>for urgent/acute medical and mental health and substance abuse disorder care via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> are covered at No charge; and \$10 copay per visit deductible does not apply for covered Specialist Care.</i></p>		
<p><b>Primary Care (PCP) virtual and office</b>  <i>The copay is waived for the first three office visits to a primary care provider per benefit period (See footnote 1)</i></p>	<p>\$0 copay per visit for visits 1-3, then \$10 copay per visit for visits 4+.            (See footnote 1)</p>	<p>All billed amounts exceeding the maximum allowed amount.            (See footnote 2)</p>

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Questions: (800) 825-5541 or visit us at [www.anthem.com/ca](http://www.anthem.com/ca)

CA/LG/SISC (Self Insured Schools of California): 90-D \$10 Anthem Classic PPO/05YX/10-01-2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Mental Health and Substance Abuse Disorder Care</b> <i>virtual and office</i></p>	<p>\$10 copay per visit deductible does not apply</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>
<p><b>Specialist Care</b> <i>virtual and office</i></p>	<p>\$10 copay per visit deductible does not apply</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>
<p><b><u>Other Practitioner Visits</u></b></p>		
<p><b>Maternity Care</b> (Prenatal and Postnatal Global Care)</p>	<p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>
<p><b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p>	<p>\$10 copay per visit deductible does not apply</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>
<p><b>Manipulation Therapy</b> <i>Pre-authorization review by American Specialty Health (ASH) is required after the 5<sup>th</sup> visit.</i></p>	<p>10% coinsurance after deductible is met</p>	<p>Not covered</p>
<p><b>Acupuncture</b> <i>Coverage is limited to 12 visits per benefit period.</i></p>	<p>10% coinsurance after deductible is met</p>	<p>50% of maximum allowed amount (See footnote 2)</p>
<p><b><u>Other Services in an Office</u></b></p>		
<p><b>Allergy Testing</b></p>	<p>10% coinsurance after deductible is met</p>	<p>Not covered</p>
<p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p>	<p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>
<p><b>Surgery</b></p>	<p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Preventive care / screenings / immunizations</b>	No charge	Not covered
<b>Preventive Care for Chronic Conditions per IRS guidelines</b>	No charge	Not covered
<b><u>Diagnostic Services</u></b> <b>Lab</b> Office Freestanding Lab Outpatient Hospital  <b>X-Ray</b> Office Freestanding Radiology Center Outpatient Hospital	 10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met  10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	 Not covered Not covered Not covered  Not covered Not covered Not covered
<b>Advanced Diagnostic Imaging for example: MRI, PET and CAT scans</b>  Office <i>Coverage for a Non-Network Provider is limited to \$800 maximum per test. (See footnote 3)</i>  Freestanding Radiology Center <i>Coverage for a Non-Network Provider is limited to \$800 maximum per test. (See footnote 3)</i>  Outpatient Hospital <i>Coverage for a Non-Network Provider is limited to \$800 maximum per test. (See footnote 3)</i>	 10% coinsurance after deductible is met  10% coinsurance after deductible is met  10% coinsurance after deductible is met	 All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)  All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)  All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b> includes doctor services. Additional charges may apply depending on the care provided.</p> <p><b>Emergency Room Facility Services</b> Copay waived if admitted.</p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b></p>	<p>\$10 copay per visit medical deductible does not apply</p> <p>\$100 copay per visit and 10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>\$100 copay per trip and 10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b><u>Outpatient Mental Health and Substance Abuse Disorder Care at a Facility</u></b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p> <p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital Services and supplies for the following outpatient surgeries are subject to a benefit limit if performed in an outpatient hospital setting. The benefit limit does not apply if performed in a Freestanding Ambulatory Surgical Center.</p> <ul style="list-style-type: none"> <li>o Arthroscopy limited to \$4,500 per procedure</li> <li>o Cataract surgery limited to \$2,000 per procedure</li> <li>o Colonoscopy limited to \$1,500 per procedure</li> <li>o Upper GI Endoscopy limited to \$1,000 per procedure</li> <li>o Upper GI Endoscopy with biopsy limited to \$1,250 per procedure</li> </ul>	<p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Ambulatory Surgical Center</b>  <i>Coverage for a Non-Network Provider is limited to \$350 maximum per day. (See footnote 3)</i></p>	<p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.  (See footnote 2 and 3)</p>
<p><b>Doctor and Other Services</b>  Hospital</p>	<p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount.  (See footnote 2)</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Abuse Disorder)</u></b>  <i>Coverage is limited to \$600 benefit maximum per day for non-emergency admission at a Non-Network provider. (See footnote 3)</i></p>		
<p><b>Facility Fees</b></p>	<p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.  (See footnote 2 and 3)</p>
<p><b>Hip/Knee/Spine Surgeries</b>  <i>For inpatient services, this benefit is covered only when performed at a designated Blue Distinction Plus Center for Specialty Care. Subject to utilization review.</i></p>	<p>10% coinsurance after medical deductible is met</p>	<p>Not Covered</p>
<p><b>Physician and other services</b> <i>including surgeon fees</i></p>	<p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount.  (See footnote 2)</p>
<p><b>Home Health Care</b>  <i>Coverage is limited to 100 visits per benefit period. Coverage for a Non-Network Provider is limited to \$150 maximum per day. (See footnote 3)</i></p>	<p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.  (See footnote 2 and 3)</p>
<p><b>Rehabilitation services</b>   Office  <i>Pre-authorization review by American Specialty Health (ASH) is required after the 5<sup>th</sup> visit).</i></p>	<p>10% coinsurance after deductible is met</p>	<p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Outpatient Hospital</p> <p><b>Pulmonary rehabilitation office and outpatient hospital</b></p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>Not covered</p> <p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>
<p><b>Cardiac rehabilitation office and outpatient hospital</b> <i>Coverage is limited to 36 visits per benefit period.</i></p> <p><b>Dialysis/Hemodialysis office and outpatient hospital</b> <i>Coverage for a Non-Network Provider is limited to \$350 maximum per visit. (See footnote 3)</i></p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>Not covered</p> <p>All billed amounts exceeding the maximum allowed amount. (See footnote 2 and 3)</p>
<p><b>Chemo/Radiation Therapy office and outpatient hospital</b></p> <p><b>Skilled Nursing Care (facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period. Coverage for a Non-Network Provider is limited to \$600 maximum per day. (See footnote 3)</i></p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p> <p>All billed amounts exceeding the maximum allowed amount. (See footnote 2 and 3)</p>
<p><b>Inpatient Hospice</b></p> <p><b>Durable Medical Equipment</b></p>	<p>No charge</p> <p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p> <p>Not covered</p>
<p><b>Prosthetic Devices</b></p> <p><b>Hearing Aids</b> <i>Coverage is limited to \$700 maximum every 24 months.</i></p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>Not covered</p> <p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>

Footnote 1: The office visit copay is waived for the first three office visits to a primary care provider per benefit period. The copay waiver applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible. Primary care providers are defined as General and Family Practitioners, Internists, Gynecologists, Obstetrics/Gynecology, Pediatricians and Nurse Practitioners. The office visit copay will apply to all other provider specialties.

Footnote 2: When using Non-Network PPO Providers, members are responsible for any difference between the maximum allowed amount and actual charges, as well as any deductible & percentage copay.

Footnote 3: The plan may pay for the following services and supplies up to the maximum number of days or visits and/or dollar maximum shown. When using non-network providers, the plan will pay the lesser of the benefit maximum or the maximum allowed amount. If the maximum allowed amount is less than the listed benefit maximum, the plan will not exceed the maximum allowed amount. Likewise, if the listed benefit maximum is less than the maximum allowed amount, the plan will not exceed the listed benefit maximum.

**Notes:**

- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Outpatient Facility tests and treatments are limited to \$350 per admission for Non-Network Providers. Includes: Surgery at Ambulatory Surgical Centers and Hemodialysis.
- Advanced Diagnostic Imaging is limited to \$800 per service for Non-Network Providers.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- The representations of benefits in this document are subject to California Department of Insurance (DOI) approval and are subject to change.

*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 Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*

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## Get help in your language Notice of Language Assistance

Curious to know what all this says? We would be too. Here's the English version:

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

### Spanish

Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

### Arabic

يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمتترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721. للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357. (TTY/TDD: 711)

### Armenian

Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հեռոնյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

### Chinese

免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者 1-888-254-2721 聯絡我們。如需更多協助，請撥打 1-800-927-4357 聯絡 CA Dept. of Insurance。 (TTY/TDD: 711)

### Farsi

خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخوانید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721 با ما تماس بگیرید. برای دریافت کمکهای بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD: 711)

### Hindi

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बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग कोकॉल करें। (TTY/TDD: 711)

**Hmong**

Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

**Japanese**

無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局 (1-800-927-4357) にお電話ください。 (TTY/TDD: 711)

**Khmer**

សេវាកម្មភាសាសេរីសេវា។ អ្នកអាចទទួលបានសេវាបកប្រែសំឡេង។ អ្នកអាចទទួលបានសេវាអានសំឡេងឯកសារ និងផ្ញើឯកសារឱ្យអ្នកជាភាសាប្រសើរ។ ដើម្បីទទួលបានសេវា សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនាមលើកាត ID របស់អ្នក ឬលេខ 1-888-254-2721។ ដើម្បីទទួលបានជំនួយ សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។ (TTY/TDD: 711)

**Korean**

무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

**Punjabi**

ਬਿਨਾਂ ਿਕਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਦੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਦੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਦੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਿਜ਼ਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਿਡਪਾਰਟਮੈਂਟ ਟ ਐਂਡ ਇਨਸ਼ੂਰੈਂਸ ਟੂ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

**Russian**

Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

**Tagalog**

Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

**Thai**

ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการล่ามได้  
ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดต่อแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357 (TTY/TDD: 711)

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## Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)

### **It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Pharmacy Benefit Schedule

### PLAN RX 5-20

	WALK-IN				MAIL	
	Network	Costco	Costco	Costco	Navitus	
Days' Supply*	30	90	30	90	90	30
Generic	\$5	N/A	FREE	FREE	FREE	N/A
Brand	\$20	N/A	\$20	\$50	\$50	N/A
Specialty	N/A	N/A	N/A	N/A	N/A	\$20

Out-of-Pocket Maximum                      \$1,500 Individual / \$2,500 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 a 30-day and/or up to a 90-day 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; however, Walgreens is **NOT** a participating pharmacy in this network.

#### 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](http://www.navitus.com)

The Navitus Member Portal allows you to access personalized pharmacy benefit information online at **[www.navitus.com](http://www.navitus.com)**. For information specific to your plan, visit the Navitus Member Portal. 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.