Your summary of benefits

Anthem BlueCross

Anthem Blue Cross

Your Plan: Your Plan: SISC Anchor Bronze HSA

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 that may apply to the coverage. For more details, important limitations and exclusions, please review the Benefit Booklet. If there is a difference between this summary and the Benefit Booklet, the Benefit Booklet 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.* *All medical services subject to a copay and coinsurance are also subject to the annual medical deductible. Deductible applies to out-of-pocket maximum.*	$5,000 member / $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.*	$6,3500 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.	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Specialist care visit	30% coinsurance.	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Prenatal and Post-natal Care	30% coinsurance.	All billed amounts exceeding the maximum allowed amount.

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
		(See footnote 1)
Other practitioner visits:		
Retail health clinic	30% coinsurance.	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Preferred Online Visits *Includes Mental/Behavioral Health and Substance Abuse.*	30% coinsurance.	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Chiropractor services *Subject to medically necessity review administered by American Specialty Health (ASH).*	30% coinsurance	Not covered
Acupuncture *Coverage for In-Network Provider and Non-Network Provider combined is limited to 12-visit limit per calendar year. (See footnote 2)*	30% coinsurance	50% of maximum allowed amount (See footnote 1)
Other services in an office:		
Allergy testing	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Chemo/radiation therapy	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Hemodialysis *Coverage for Out-of-Network Provider is limited to $350 maximum per visit. (See footnote 2)*	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	30% coinsurance	All billed amounts exceeding the

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
		maximum allowed amount. (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. (See footnote 2)*	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Freestanding Radiology Center *Coverage for Out-of-Network Provider is limited to $800 maximum per test. (See footnote 2)*	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $800 maximum per test. (See footnote 2)*	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Emergency and Urgent Care		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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 and then 30% coinsurance	Covered at the In-Network level of benefits (See footnote 1)
Emergency room doctor and other services	30% coinsurance	Covered at the In-Network level of benefits (See footnote 1))
Ambulance (air and ground)	$100 copay per trip, then 30% coinsurance	Covered at the In-Network level of benefits (See footnote 1)
Urgent Care (physician services)	30% coinsurance.	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	30% coinsurance.	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Facility visit:		
Facility fees	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Outpatient Surgery		
Facility fees:		
Hospital	30% coinsurance	All billed amounts exceeding the

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
		maximum allowed amount. (See footnote 1)
Services and supplies for the following outpatient surgeries are subject to a benefit limit if performed in an outpatient hospital: ○ 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	30% coinsurance up to benefit limit	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Freestanding Ambulatory Surgical Center *Coverage for Out-of-Network Provider is limited to $350 maximum per day. (See footnote 2)*	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Doctor and other services	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Coverage is limited to $600 benefit maximum per day for non-emergency admission at a Non-Network provider. (See footnote 2)*	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Doctor and other services	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Recovery & Rehabilitation		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100-visit limit per calendar year. (See footnote 2)* *Coverage for Out-of-Network Provider is limited to $150 maximum per day. (See footnote 2)*	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Rehabilitation Habilitation services (for example, physical/occupational therapy):		
Office	30% coinsurance	Not covered
Outpatient hospital	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. (See footnote 2)* *Coverage for Out-of-Network Provider is limited to $600 maximum per day. (See footnote 2)*	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Hospice	No charge	All billed amounts exceeding the maximum allowed amount. (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. (See footnote 2)*	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Hearing Aids *Benefit is limited to $700 every 24 months. (See footnote 2)*	30% coinsurance	All billed amounts exceeding the

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
		maximum allowed amount. (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. (See footnote 2)*	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Home Infusion Therapy *Coverage for Out-of-Network Provider is limited to $600 per day. Subject to utilization review. (See footnote 2)*	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Speech Therapy	30% coinsurance	All billed amounts exceeding the maximum allowed amount. (See footnote 1)

Footnote 1: 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 2: The plan may pay for the following services and supplies up to the maximum number of days or visits 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:

- 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.
- All medical services subject to a copay and 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.
- For plans with an office visit copay, the copay 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.
- 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 an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- 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.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees 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.

- 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 Benefit Booklet for full details on your covered benefits.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees 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.

SISC
Self-Insured Schools of California
Schools Helping Schools

NAVITUS
HEALTH SOLUTIONS

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.

**Both the Deductible and Out-of-Pocket Maximum apply 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.