Your summary of benefits

Anthem®

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: SISC (Self Insured Schools of California): 80-M $40 Anthem Classic PPO

Your Network: Select PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	$40 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$3,000 person / $6,000 family	$3,000 person / $6,000 family
Overall Out-of-Pocket Limit	$4,000 person / $8,000 family	No limit person / No limit family
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. All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit. In-Network and Non-Network deductibles are combined and accumulate toward each other. *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.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) *virtual and office* *The copay is waived for the first three office visits to a primary care provider per benefit period*	$0 copay per visit for visits 1-3, then $40 copay per visit for visits 4+	All billed amounts exceeding the maximum allowed amount*
Mental Health and Substance Use Disorder Services *virtual and office*	$40 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care *virtual and office*	$40 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount*
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal Global Care)	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$40 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount*
Manipulation Therapy *Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit of physical, occupational or chiropractic care.*	20% coinsurance after deductible is met	Not covered
Acupuncture *Coverage is limited to 12 visits per benefit period.*	20% coinsurance after deductible is met	50% of maximum allowed amount*
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	Not covered
Prescription Drugs *Dispensed in the office* .	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Surgery	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services		
Lab		
Office	20% coinsurance after deductible is met	Not covered
Freestanding Lab	20% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
X-Ray		
Office	20% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office *Coverage for a Non-Network Provider is limited to $800 maximum per test*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Freestanding Radiology Center *Coverage for a Non-Network Provider is limited to $800 maximum per test*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Outpatient Hospital *Coverage for a Non-Network Provider is limited to $800 maximum per test*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$40 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount*
Emergency Room Facility Services *Your copay will be waived if admitted.*	$100 copay per visit and 20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance *Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	$100 copay per trip and 20% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Doctor Services	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Outpatient Surgery		
Facility Fees		
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.* 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*	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Ambulatory Surgical Center *Coverage for a Non-Network Provider is limited to $350 maximum per day.*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) *Anthem's maximum payment is up to $600 per day for non-emergency Inpatient admissions to non-network providers.*		
Facility Fees	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hip/Knee/Spine Surgeries *For inpatient services, this benefit is covered only when performed at a designated Blue Distinction Plus Center for Specialty Care. Subject to utilization review.*	20% coinsurance after deductible is met	Not covered
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Home Health Care *Coverage is limited to 100 visits per benefit period.* *Coverage for a Non-Network Provider is limited to $150 maximum per day*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.*		
Office *Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit of physical, occupational or chiropractic care.*	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Cardiac rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis *office and outpatient hospital* *Coverage for a Non-Network Provider is limited to $350 maximum per visit.*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (facility) *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.*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Inpatient Hospice	No charge	All billed amounts exceeding the maximum allowed amount*
Durable Medical Equipment	20% coinsurance after deductible is met	Not covered
Prosthetic Devices	20% coinsurance after deductible is met	Not covered
Hearing Aids *Coverage is limited to $700 maximum every 24 Months.*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*

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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- Surgery at Ambulatory Surgical Centers and Hemodialysis are limited to $350 per admission for Non-Network Providers.
- 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 office visit copay is waived for the first three office visits to a Primary Care Physician 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 Physician is defined as General and Family Practitioner, Internist, Gynecologist, Obstetric/Gynecology, Pediatrician and Nurse Practitioner. The office visit copay will apply to all other provider specialties.

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

Anthem

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Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (800) 825-5541

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.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 825-5541 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 825-5541:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(800) 825-5541。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 825-5541 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 825-5541.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (800) 825-5541.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 825-5541.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(800) 825-5541 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(800) 825-5541로 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bááh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (800) 825-5541.

Language Access Services:

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (800) 825-5541.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (800) 825-5541 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (800) 825-5541.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (800) 825-5541.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (800) 825-5541.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (800) 825-5541.

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.

SISC
Self-Insured Schools of California
Schools Helping Schools

NAVITUS HEALTH SOLUTIONS

Pharmacy Benefit Schedule

PLAN RX 200DED/10-35

	WALK-IN				MAIL	
	Network		Costco		Costco	Navitus
Days' Supply*	30	90	30	90	90	30
Generic	$10	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	$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. Monies paid in the 4th quarter (October-December) towards the deductible are carried over to the next calendar year.

*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 90day supply programs. Navitus contracts with most independent and chain pharmacies; however, Walgreens is **NOT** a participating pharmacy in this network.

**Deductible only applies to Brand and Specialty drugs. Copays apply only after the brand deductible is met.

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

The Navitus Member Portal allows you to access personalized pharmacy benefit information online at **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.