# Your summary of benefits

Anthem®

Anthem® Blue Cross

Your Plan: SISC (Self Insured Schools of California): Value HMO

Your Network: Priority Select HMO

| 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 |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Overall Deductible** | $0 person |
| **Overall Out-of-Pocket Limit** | $2,500 single /<br>$5,000 family |
| To get benefits under this Plan, you must use In-Network Providers. **Services from Non-Network Providers are not covered**, except for Emergency or Urgent Care, Authorized Services, or when required by law. Please be sure to contact us if you are not sure if we have approved an Authorized Service.<br>The family out-of-pocket limit is embedded, meaning each covered person is capped at his or her per single out-of-pocket limit; in addition, cost shares for all covered family members apply to the family out-of-pocket limit, yet no one member will pay more than the per single out-of-pocket limit.<br>All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit. | |
| **Doctor Visits (virtual and office)** *Your plan requires the selection of a Primary Care Physician (PCP). A referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services.* | |
| **Primary Care (PCP) and Mental Health and Substance Use Disorder Services** *virtual and office* | $30 copay per visit |
| **Specialist Care** *virtual and office* | $40 copay per visit |
| **Other Practitioner Visits** | |
| **Routine Maternity Care** (Prenatal and Postnatal) | $30 copay per visit |
| **Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | $30 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Manipulation Therapy**<br>*Coverage is limited to 20 visits per benefit period.* | $30 copay per visit |
| **Acupuncture**<br>*Coverage is limited to 20 visits per benefit period.* | $30 copay per visit |
| **Other Services in an Office** | |
| **Allergy Testing** | $30 copay per visit |
| **Prescription Drugs** *Dispensed in the office*<br>*Maximum of $150 member cost share per drug.* | 30% coinsurance |
| **Surgery** | $30 copay per surgery |
| **Preventive care / screenings / immunizations** | No charge |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge |
| **Diagnostic Services**<br>**Lab** | |
| Office | No charge |
| Freestanding Lab | No charge |
| Outpatient Hospital | No charge |
| **X-Ray** | |
| Office | No charge |
| Freestanding Radiology Center | No charge |
| Outpatient Hospital | No charge |
| **Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | |
| Office | $100 copay per service |
| Freestanding Radiology Center | $100 copay per service |
| Outpatient Hospital | $100 copay per service |
| **Emergency and Urgent Care** | |
| **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.* | **In-Network and Non-Network Providers:**<br>$30 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Emergency Room Facility Services**<br>*Your copay will be waived if admitted.* | **In-Network and Non-Network Providers:**<br>$150 copay per visit |
| **Emergency Room Doctor and Other Services** | **In-Network and Non-Network Providers:**<br>No charge |
| **Ambulance**<br>*Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.* | **In-Network and Non-Network Providers:**<br>$100 copay per trip |
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | |
| Facility Fees | No charge |
| Doctor Services | No charge |
| **Outpatient Surgery** | |
| **Facility Fees** | |
| Hospital | $250 copay per visit |
| Ambulatory Surgical Center | $250 copay per visit |
| **Physician and other services** *including surgeon fees* | |
| Hospital | No charge |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)**<br>*If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.* | |
| **Facility Fees** | $500 copay per day up to 3 days per admission |
| **Physician and other services** *including surgeon fees* | No charge |
| **Home Health Care**<br>*Coverage is limited to 100 visits per benefit period.* | $30 copay per visit |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.*<br>*Coverage for physical and occupational therapies is limited to 40 visits combined per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.* | |
| Office | $30 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| Outpatient Hospital | $40 copay per visit |
| **Pulmonary rehabilitation** | |
| Office | $30 copay per visit |
| Outpatient Hospital | $40 copay per visit |
| **Cardiac rehabilitation**<br>*Coverage is limited to 36 visits per benefit period.* | |
| Office | $30 copay per visit |
| Outpatient Hospital | $40 copay per visit |
| **Dialysis/Hemodialysis** *office and outpatient hospital* | $40 copay per visit |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | $40 copay per visit |
| **Skilled Nursing Care (facility)**<br>*Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.* | No charge |
| **Inpatient Hospice** | No charge |
| **Durable Medical Equipment** | 50% coinsurance |
| **Prosthetic Devices** | No charge |

**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.
- 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 Managed Health Care (DMHC) 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.*

*Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental health and substance use disorders. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.*

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

Anthem

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# Your summary of benefits

Anthem.

Anthem® Blue Cross

Your Plan: Chiropractic-Manipulative Treatment/Acupuncture Rider (HMO)

Your Network: ASH

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| Benefits described in this section are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California, Inc. (ASH Plans). The services described in this section are covered only if provided by a chiropractor or acupuncturist that is an In-Network Provider. These benefits are in addition to the benefits described in the "Therapy Services" provision within the Evidence of Coverage (EOC). However, when you are treated by a chiropractor or acupuncturist that is an In-Network Provider, services will not be covered other than those benefits specifically described in this section. You may search for chiropractors or acupuncturists that are In-Network Providers using the "Find Care" function on our website at www.anthem.com/ca and select the HMO Chiropractic/Acupuncture Network (American Specialty Health Plans). | | |
| **Your First Visit** You must make an appointment with a chiropractor or acupuncturist that is an In-Network Provider for an examination of your condition. You do not need a referral from your Medical Group or Primary Care Physician to see a chiropractor or acupuncturist that is an In-Network Provider.<br><br>**Services Must be Approved** All services must be approved as Medically Necessary except for:<br><br>• An initial new patient exam by a chiropractor or acupuncturists that are In-Network Provider and the provision or commencement, during the initial new patient exam, of Medical Necessary services that are chiropractic and acupuncture services, to the extent services are consistent with professionally recognized, valid, evidence-based standards of practice; and<br>• Emergency Services.<br><br>If additional services are required after the initial new patient exam and they are approved as Medically Necessary, you are covered up to the maximum number of visits shown below. All visits will be applied towards the maximum number of visits in a Benefit Period.<br><br>**Services Not Approved** A chiropractor or acupuncturists that is an In-Network Provider may provide non-Covered Services. However, you must agree in writing, before receiving non-Covered Services, to pay for them yourself. If a chiropractor or an acupuncturist that is an In-Network Provider provides non-Covered Services without obtaining your written acknowledgement prior to providing the non-Covered Services, you will not be financially responsible to pay the provider for such non-Covered Services. | | |
| **Visits in an Office & Outpatient**<br><br>**Chiropractic Care**<br>*Coverage is limited to 30 visits per benefit period. Benefit limit is for office and outpatient combined. Benefit maximum is for Chiropractic Care Services and Acupuncture Services combined.* | $10 copay per visit | Not covered |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Acupuncture**<br>*Coverage is limited to 30 visits per benefit period. Benefit limit is for office and outpatient combined. Benefit maximum is for Chiropractic Care Services and Acupuncture Services combined.* | $10 copay per visit | Not covered |
| **Diagnostic Services**<br>**Lab**<br>**Chiropractic labs**<br>*Covered when prescribed by a chiropractor that is an In-network Provider and approved as Medically Necessary.* | Covered at the same cost share percentage as Diagnostic Labs. | Not covered |
| **Chiropractic X-Ray**<br>*Covered when prescribed by a chiropractor that is an In-network Provider and approved as Medically Necessary.* | Covered at the same cost share percentage as Diagnostic X-ray. | Not Covered |
| **Durable Medical Equipment**<br>**Chiropractic appliances**<br>*Covered when prescribed by a chiropractor that is an In-Network Provider and approved as Medically Necessary.* | $50 maximum of Chiropractic Appliances per Benefit Period. | Not Covered |

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*Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.*

# Your summary of benefits

Anthem.

Anthem® Blue Cross

Your Plan: Custom Hearing Aid Rider (HMO)

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Hearing Aids**<br>*Coverage is limited to one hearing aid device per ear every 36 months.* | 50% coinsurance | Not Covered |

The following hearing aids services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or state-certified audiologist at the above cost share and apply above Member benefit Maximum.

- Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under Plan benefits for office visits to Physicians.
- Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords, and other ancillary equipment.
- Visits for fitting, counseling, adjustments, and repairs for a one-year period after receiving the covered hearing aid.
- Includes bone-anchored and FDA approved over-the-counter hearing aids with a prescription.

Benefits will not be provided for charges for a hearing aid, which exceeds specifications prescribed for the correction of hearing loss, or for more than the benefit maximums found above and in the Evidence of Coverage (EOC).

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This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

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# Get help in your language

## Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (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
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(TTY/TDD:711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

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重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸ ਇਹ ਪੱਤਰ ਪੜਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹ , ਤਾਂ ਅਸ ਇਸ ਨੂੰ ਪੜਹ੍ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਿਖਆ ਹੋਇਆ ਵਬੀ ਪਰ੍ਾਪ ੍ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੈਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (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

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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.

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SISC
Self-Insured Schools of California
*Schools Helping Schools*

NAVITUS HEALTH SOLUTIONS

# Pharmacy Benefit Schedule

## PLAN RX 7-25

| | WALK-IN | | | | MAIL | |
|---|---|---|---|---|---|---|
| | Network | | Costco | | Costco | Navitus |
| Days' Supply* | 30 | 90 | 30 | 90 | 90 | 30 |
| Generic | $7 | N/A | FREE | FREE | FREE | N/A |
| Brand | $25 | N/A | $25 | $60 | $60 | N/A |
| Specialty | N/A | N/A | N/A | N/A | N/A | $25 |

| | |
|---|---|
| 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

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.