blue of california

Summary of Benefits

Self-Insured Schools of California
Effective October 1, 2025
PPO Plan

90% Plan G $20 Copayment

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.[1] Please read both documents carefully for details.

Provider Network: Full PPO Network

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before the Claims Administrator pays for Covered Services under the Plan. The Claims Administrator pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$500
	Family coverage	$500: individual $1,000: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$1,000
Family coverage	$1,000: individual $3,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services.

Blue Shield of California is an independent member of the Blue Shield Association

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		Not covered	
Physician services[10]				
Primary care office visit	$20/visit		50%	✔
Specialist care office visit	$20/visit		50%	✔
Physician home visit	$20/visit		50%	✔
Physician or surgeon services in an Outpatient Facility	10%	✔	50%	✔
Physician or surgeon services in an inpatient facility	10%	✔	50%	✔
Other professional services[10]				
Other practitioner office visit	$20/visit		50%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	10%	✔	50%	✔
Up to 12 visits per Member, per Calendar Year.				
Chiropractic services	10%	✔	Not covered	
Up to 20 visits per Member, per Calendar Year.				
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive	$0		Not covered	
• Diaphragm fitting	$0		Not covered	
• Intrauterine device (IUD)	$0		Not covered	
• Insertion and/or removal of intrauterine device (IUD)	$0		Not covered	
• Implantable contraceptive	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	10%	✔	Not covered	
• Diagnosis and Treatment of the Cause of Infertility	Not covered		Not covered	
Podiatric services	$20/visit		50%	✔
Medical nutrition therapy, not related to diabetes	10%	✔	50%	✔
Pregnancy and maternity care[7, 10]				
Physician office visits: prenatal and postnatal	$20/visit		50%	✔
Physician services for pregnancy termination	10%	✔	Not covered	
Certified nurse midwives	10%	✔	10%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Emergency Services				
Emergency room services	$100/visit plus 10%	✔	$100/visit plus 10%	✔
If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.				
Emergency room Physician services	10%	✔	10%	✔
Urgent care center services[10]	$20/visit		50%	✔
Ambulance services	$100/transport plus 10%	✔	$100/transport plus 10%	✔
This payment is for emergency or authorized transport.				
Outpatient Facility services				
Ambulatory Surgery Center	10%	✔	All charges above $350	✔
Outpatient Department of a Hospital: surgery	10%	✔	All charges above $350	✔
Arthroscopy[8]	10% Subject to a Benefit maximum of $4,500/procedure	✔	Not covered	
Cataract Surgery[8]	10% Subject to a Benefit maximum of $2,000/procedure	✔	Not covered	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	✔	50% Subject to a Benefit maximum of $350/day	✔
Inpatient facility services				
Hospital services and stay	10%	✔	All charges above $600	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Transplant services				
This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.				
• Special transplant facility inpatient services	10%	✔	Not covered	
• Physician inpatient services	10%	✔	Not covered	
Transplant Travel Benefit: Maximum payment will not exceed $10,000 per transplant, (not per lifetime) Ground transportation to and from the Center of Excellence (COE) when the designated COE is 75 miles or more from the recipient's or donor's place of residence. Coach airfare to and from the COE when the designated COE is 300 miles or more from the recipient's or donor's residence.	All charges above $10,000/ transplant		Not covered	
Bariatric surgery services, designated California counties				
This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and outpatient Physician services payments apply.				
Inpatient facility services	10%	✔	Not covered	
Outpatient Facility services	10%	✔	Not covered	
Physician services	10%	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory and pathology services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	10%	✔	Not covered	
• Outpatient Department of a Hospital	10%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Basic imaging services				
Includes plain film X-rays, ultrasounds, and diagnostic mammography.				
• Outpatient radiology center	10%	✔	Not covered	
• Outpatient Department of a Hospital	10%	✔	Not covered	
Other outpatient non-invasive diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	10%	✔	Not covered	
• Outpatient Department of a Hospital	10%	✔	Not covered	
Advanced imaging services				
Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.				
• Outpatient radiology center	10%	✔	50%	✔
• Outpatient Department of a Hospital	10%	✔	50% Subject to a Benefit maximum of $350/day	✔
Colonoscopy[8]	10% Subject to a Benefit maximum of $1,500/procedure	✔	Not covered	
Upper GI Endoscopy[8]	10% Subject to a Benefit maximum of $1,000/procedure	✔	Not covered	
Upper GI Endoscopy with Biopsy[8]	10% 10% Subject to a Benefit maximum of $1,250/procedure	✔	Not covered	
Rehabilitative and Habilitative Services				
Includes physical therapy, occupational therapy, and respiratory therapy.				
Office location	10%	✔	Not covered	
Outpatient Department of a Hospital	10%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Speech Therapy services				
Office location	10%	✔	50%	✔
Outpatient Department of a Hospital	10%	✔	50%	✔
Durable medical equipment (DME)				
DME	10%	✔	Not covered	
Breast pump	$0		Not covered	
Orthotic equipment and devices	10%	✔	Not covered	
Up to 2 pairs of shoes and 2 inserts for therapeutic shoes per Calendar Year. Additional 2 pair of orthotics allowed post-surgery				
Prosthetic equipment and devices	10%	✔	50%	✔
Home health care services	10%	✔	50%	✔
Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.				
Home infusion and home injectable therapy services				
Home infusion agency services	10%	✔	50%	✔
Includes home infusion drugs, medical supplies, and visits by a nurse.				
Hemophilia home infusion services	10%	✔	50%	✔
Includes blood factor products.				
Skilled Nursing Facility (SNF) services				
Up to 150 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.				
Freestanding SNF	10%	✔	10%	✔
Hospital-based SNF	10%	✔	All charges above $600	✔
Hospice program services				
Pre-Hospice consultation	$0		50%	✔
Routine home care	$0		50%	✔
24-hour continuous home care	$0		50%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Short-term inpatient care for pain and symptom management	$0		50%	✔
Inpatient respite care	$0		50%	✔
Other services and supplies[10]				
Diabetes care services				
• Devices, equipment, and supplies	10%	✔	50%	✔
• Self-management training	$20/visit		50%	✔
• Medical nutrition therapy	$20/visit		50%	✔
Dialysis services	10%	✔	50% Subject to a Benefit maximum of $350/day	✔
PKU product formulas and special food products	10%	✔	Not covered	
Allergy serum billed separately from an office visit	10%	✔	50%	✔
Hearing aid services				
• Hearing aids and equipment *Up to $700 combined maximum per Member, per 24-month period.*	10%	✔	10%	✔
• Audiological evaluations	$20/visit		50%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$20/visit		50%	✔
Intensive outpatient care	10%	✔	50%	✔
Behavioral Health Treatment in an office setting	10%	✔	50%	✔
Behavioral Health Treatment in home or other non-institutional setting	10%	✔	50%	✔
Office-based opioid treatment	10%	✔	50%	✔
Partial Hospitalization Program	10%	✔	50% Subject to a Benefit maximum of $350/day	✔
Psychological Testing	10%	✔	50%	✔
Inpatient services				
Physician inpatient services	10%	✔	50%	✔

Mental Health and Substance Use Disorder Benefits

	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Hospital services	10%	✔	All charges above $600	✔
Residential Care	10%	✔	All charges above $600	✔

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services

Please review the Benefit Booklet for more about Benefits that require prior authorization.

Notes

1 Benefit Booklet:

The Benefit Booklet describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

Capitalized terms are defined in the Benefit Booklet. Refer to the Benefit Booklet for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before the Claims Administrator pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by the Claims Administrator before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

This Plan has a combined Participating Provider and Non-Participating Provider Calendar Year Deductible.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

Notes

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount.
- Any charges above the specified Benefit maximum are not covered, do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.
- Some Benefits from Non-Participating Providers have the Allowable Amount or Benefit maximum listed in the Benefits chart as a specific dollar ($) amount. You are responsible for any charges above the Allowable Amount or Benefit maximum, whether or not an amount is listed in the Benefits chart.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered and charges above the Allowable Amount.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This benefit Plan has a combined Participating Provider and Non-Participating Provider OOPM. However, only the following Non-Participating Provider services will accrue to the combined OOPM:

- Ambulance services;
- Emergency services;
- Certified Nurse Midwives;
- Skilled nursing facilities (SNF) services at a Freestanding SNF; and
- Hearing aids and equipment.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example,

you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

8 Outpatient Facility Services:

Services and supplies for the following Outpatient surgeries are subject to a Benefit maximum if performed in the Outpatient department of a Hospital: athroscopy, cataract surgery, colonoscopy, upper GI endoscopy, and upper GI endoscopy with biopsy. The Benefit maximum does not apply when the same services are provided in a participating Ambulatory Surgery Center.

9 For Services by Non-Preferred and Non-Participating Providers:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

You are responsible for all charges above the Allowable Amount. However, if the Non-Preferred/Non-Participating/ Provider is a Hospital based Physician performing Services at a Participating Provider (in-network) facility; or out of network lab services, when performed by an in-network (participating) provider, but sent to a non-participating provider for processing, the Claims Administrator's payment will be made at the Participating Provider copayment level.

Authorized Referrals for Services by Non-Preferred/Non-Participating Providers –

In some circumstances, the Claims Administrator may authorize participating provider cost share amounts (Deductibles or Co-Payments, if applicable) to apply to a claim for a covered service you receive from a non-participating provider. In such circumstance, you or your physician must contact the Claims Administrator in advance of obtaining the covered service. It is your responsibility to ensure that the Claims Administrator has been contacted. If the Claims Administrator authorizes a participating provider cost share amount to apply to a covered service received from a non-participating provider, you also may still be liable for the difference between the maximum allowed amount and the non-participating provider's charge. Please call the customer service telephone number on the back of your ID card for authorized referral information or to request authorization.

Authorized referral occurs when you, because of your medical needs, are referred to a non-participating provider, but only when:

a. There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence;
b. You are referred in writing to the non-participating provider by the physician who is a participating provider, and
c. The referral has been authorized by the Claims Administrator before services are rendered. You or your physi-cian must call the toll-free telephone number printed on the back of your identification card prior to scheduling an admission to, or receiving the services of, a non-participating provider. Such authorized referrals are not available for transplant and bariatric surgical services. These services are only covered when performed at a COE.

Notes

10 First Dollar Coverage:

This Plan offers first dollar coverage for 3 office visits with Participating Providers. This means the Claims Administrator will pay for these Covered Services before you are charged a Copayment.

First dollar coverage is available for office visits with a Participating Physician, for any combination of these Provider types:

- General practice
- Family practice
- Internal Medicine
- Pediatrics
- Nurse Practitioner
- Physician's Assistant
- Obstetrics
- Gynecology

After you reach the 3 office visit maximum under the first dollar coverage benefit, additional office visits in the same Calendar Year are subject to the applicable Participating Provider office visit Copayment.

Non-Participating Provider office visits are not covered under the first dollar coverage. These services are covered as described in the Benefits chart above.

Plans may be modified to ensure compliance with Federal requirements.

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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.