

# Your summary of benefits



Anthem® Blue Cross Life and Health Insurance Company

Your Plan: SISC (Self Insured Schools of California): Proactive Care Plan: **Gold**

Your Network: Anthem Prudent Buyer PPO

Visits with Virtual Care-Only Providers	Cost if you use an In-Network Provider
<b>Primary Care, and medical services for urgent / acute care</b>	No charge
<b>Mental Health &amp; Substance Use Disorder Services</b>	No charge

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>No Deductible</b>	\$0 person / \$0 Family	\$0 person* / \$0 Family*
<b>Overall Out-of-Pocket Limit</b>	\$3,000 person / \$6,000 family	No limit per person* / No limit per family*

There is no deductible. The out-of-pocket limit is embedded, meaning the cost shares of one family member will be applied to per person out-of-pocket limit; in addition, amounts for all covered family members apply to the family out-of-pocket limit. No one member will pay more than the per person out-of-pocket limit.

All copayments for covered services with in-network providers apply to the out-of-pocket limit.

\*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):

### Maximize your Proactive Care benefits when you seek care from a Primary Care Provider (PCP)

<b>Primary Care (PCP) virtual and office</b> <i>Primary Care Providers (PCPs) are those without specialty certifications, practicing general pediatrics, internal medicine, family or general practice, or obstetrics and gynecology.</i>	\$0 Copay	All billed amounts exceeding the maximum allowed amount*
<b>Urgent Care</b>	\$0 Copay	All billed amounts exceeding the maximum allowed amount*
<b>Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$0 Copay	All billed amounts exceeding the maximum allowed amount*
<b>Specialist Care virtual and office</b> <i>Copay applies to the office visit. Additional testing / diagnostic / surgical services are subject to the applicable copay for those services.</i>	\$100 copay	All billed amounts exceeding the maximum allowed amount*

<b>Other Practitioner Visits</b>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<b>Routine Maternity Care</b> <i>virtual and office</i> (Prenatal and Postnatal Global Care)	\$0 copay	All billed amounts exceeding the maximum allowed amount*
<b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$0 copay	All billed amounts exceeding the maximum allowed amount*
<b>Manipulation Therapy</b> <i>Pre-authorization review is required after the 5<sup>th</sup> visit of physical, occupational, or chiropractic care.</i>	\$0 copay	Not covered
<b>Acupuncture</b> <i>Limited to 12 visits per calendar year.</i>	\$0 copay	50% of maximum allowed amount*
<b>Other Services in an Office</b>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<b>Allergy Testing</b>	\$0 PCP/\$100 Specialist	Not covered
<b>Prescription Drugs</b> <i>Dispensed in the office</i>	\$0 PCP/\$35 Specialist	All billed amounts exceeding the maximum allowed amount*
<b>Surgery</b>	\$0 PCP /\$300 Specialist	All billed amounts exceeding the maximum allowed amount*
<b>Preventive Care / Screenings / Immunizations</b>	No charge	Not covered
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	Not covered
<b>Diagnostic Services - Lab</b>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<b>Office Lab</b>	\$0 copay	Not covered
<b>Freestanding Lab</b>	\$0 copay	Not covered
<b>Outpatient Hospital Lab</b>	\$150 copay	Not covered
<b>X-Ray</b>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<b>Office</b>	\$0 copay PCP / \$75 specialist	Not covered
<b>Freestanding Radiology Center</b>	\$75 copay	Not covered
<b>Outpatient Hospital</b>	\$225 copay	Not covered

<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans. Coverage for a Non-Network Provider is limited to \$800 maximum per test.</i>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<b>Freestanding Radiology Center</b>	\$300 copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.
<b>Outpatient Hospital</b>	\$750 copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.
<b>Emergency Care</b>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<b>Emergency Room Facility and Doctor Services</b> <i>Your ER copay will be waived if admitted. Inpatient Hospital copay(s) apply if admitted.</i>	\$700 copay	Covered as In-Network
<b>Emergency - Other Services</b> <i>Copay applies to visit. Additional testing / diagnostic / surgical services are subject to the applicable copay for those services.</i>	Applicable outpatient / Inpatient copays	Covered as In-Network
<b>Ambulance</b> <i>Authorized Non-Network non-emergency ambulance services are limited to a maximum payment of \$50,000 per trip.</i>	\$700 (ground or air)	Covered as In-Network
<b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<b>Facility Fees</b> <i>Prior Auth Required</i>	\$0 per day	All billed amounts exceeding the maximum allowed amount*
<b>Doctor Services</b>	Included in per day Facility fee.	All billed amounts exceeding the maximum allowed amount*
<b>Outpatient Procedures</b>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<b>Outpatient Procedure at an ASC</b> , including surgeon fees	\$600 copay	All billed amounts exceeding the maximum allowed amount*
<b>Outpatient Procedure at a Hospital</b> , including surgeon fees	\$1,800 copay	All billed amounts exceeding the maximum allowed amount*
<b>Inpatient Hospital {Including Maternity, Mental Health, and Substance Use Disorder Services}</b> <i>Coverage for non-emergency inpatient admissions to non-network providers is limited to \$600 maximum per day.</i>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<b>Facility Fees</b>	\$600 copay per day	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed

		amount*
<b>Hip / Knee / Spine Surgeries</b> <i>Please refer to Blue Distinction Center Program Travel Benefit. Maximum of \$6,000 per surgery is covered if plan participant's home is 50 miles more from nearest hip replacement / knee replacement / spine Blue Distinction Center.</i> <i>Carrum Program may provide a \$0 cost alternative. Please refer to Carrum Program.</i>	Included in the \$600 per day copay.	Not Covered
<b>Physician and other services including surgeon fees</b>	Included in the \$600 per day copay.	All billed amounts exceeding the maximum allowed amount
<b>Home Health Care</b> <i>Limited to 100 visits per calendar year.</i> <i>Coverage for a Non-Network Provider is limited to \$150 maximum per day.</i>	\$0 copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
<b>Rehabilitation and Habilitation Services</b>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<b>Office</b> <i>Limited to 36 office and outpatient visits per calendar year combined.</i>	\$0 copay	Not covered
<b>Outpatient Hospital</b> <i>Limited to 36 office and outpatient visits per calendar year combined.</i>	\$0 copay	Not covered
<b>Pulmonary rehabilitation office and outpatient hospital</b> <i>Limited to 36 office and outpatient visits per calendar year combined.</i>	\$0 copay	All billed amounts exceeding the maximum allowed amount*
<b>Cardiac rehabilitation office and outpatient hospital</b> <i>Limited to 36 office and outpatient visits per calendar year combined.</i>	\$0 copay	Not covered
<b>Dialysis Hemodialysis</b> <i>Coverage for a Non-Network Provider is limited to \$350 maximum per visit.</i>	\$0 copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
<b>Chemo/Radiation Therapy</b>	\$0 copay	All billed amounts exceeding the maximum allowed amount*
<b>Skilled Nursing Care (facility)</b> <i>Limited to 150 days per calendar year.</i>	\$1,200 copay per admission	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*

<b>Inpatient Hospice</b>	\$0 copay	All billed amounts exceeding the maximum allowed amount*
<b>Durable Medical Equipment</b> <i>Pre-certification required for DME in excess of \$1,000 purchase / rental price.</i>	\$0 copay	Not covered
<b>Prosthetic Devices</b>	\$0 copay	Not covered
<b>Hearing Aids</b> <i>Limited to \$700 per plan participant, per 24-month period.</i>	\$0 copay	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 “Primary Care (PCP) virtual and office,” “Specialist Care virtual and office,” or “Urgent Care” respectively.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Plan Benefit Booklet 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.
- 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.

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

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Questions: (800) 888-8288 or visit us at [www.anthem.com/ca](http://www.anthem.com/ca)

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# Get help in your language

## Notice of Language Assistance



The SISC Proactive Care Plan has Spanish bilingual capabilities through customer service employees. LanguageLine Solutions, which provides interpreters for over 240 languages, is also available to SISC members enrolled on this plan.

Please visit [www.languageline.com/interpreting/interpreting-languages](http://www.languageline.com/interpreting/interpreting-languages) for a list of the languages supported. The service is utilized during standard hours of operation. Additionally, Google Translate enables users to change the language of the member portal.

### 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

### Proactive Care Plan RX 9-35

	WALK-IN			MAIL	
<b>PHARMACY</b>	NETWORK	COSTCO	COSTCO	COSTCO	NAVITUS
<b>DAYS SUPPLY</b>	30	30	90	90	30
<b>GENERIC</b>	\$9	FREE	FREE	FREE	
<b>BRAND</b>	\$35	\$35	\$90	\$90	
<b>PREFERRED BRAND (TIER 0)</b>	FREE	FREE	FREE	FREE	
<b>SPECIALTY</b>					\$35
<b>OUT-OF-POCKET MAXIMUM</b>	\$2,500 INDIVIDUAL / \$3,500 FAMILY				
<b>PREFERRED</b>	ON PREFERRED DRUG LIST				
<b>TIER 0 DRUGS WHEN PRESCRIBED BY AN IN-NETWORK PRIMARY CARE PROVIDER (INCL. INTERNAL MEDICINE, GENERAL/FAMILY, PEDIATRICS, AND OBGYN)</b>	<p>\$0 FOR THE FOLLOWING MEDICATIONS</p> <ul style="list-style-type: none"> <li>• Asthma Inhalers like Qvar, Arnuity Ellipta, Albuterol</li> <li>• Diabetic medications like Ozempic, Jardiance, Mounjaro, Rybelsus, Trulicity <ul style="list-style-type: none"> <li>• Insulins like insulin Lispro, Humalog, Semglee</li> <li>• Anticoagulants like Xarelto, Eliquis</li> <li>• Specialty Medicines like Dupixent, Xolair</li> <li>• Biosimilars like Adalimumab-adaz, Hadlima</li> </ul> </li> </ul>				

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.