

Your summary of benefits



Anthem® Blue Cross Life and Health Insurance Company

Your Plan: SISC (Self Insured Schools of California): HSA \$3,400 (HSA Compatible Classic)

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 after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	10% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$3,400 person / \$6,800 family	\$3,400 person / \$6,800 family
Overall Out-of-Pocket Limit	\$6,000 person / \$12,000 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 Out-of-Network deductibles are combined and accumulate towards each other.

In-Network and Out-of-Network out-of-pocket limit amounts are separate and do not 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) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Specialist Care <i>virtual and office</i>	10% 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 an Out-of-Network Provider
<p><u>Other Practitioner Visits</u></p> <p>Routine Maternity Care Doctor services (prenatal/postnatal care and delivery)</p> <p>Retail Health Clinic <i>For routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p>Manipulation Therapy <i>Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit of physical, occupational or chiropractic care.</i></p> <p>Acupuncture <i>Coverage is limited to 12 visits per benefit period.</i></p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount*</p> <p>All billed amounts exceeding the maximum allowed amount*</p> <p>Not covered</p> <p>50% of maximum allowed amount*</p>
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>Not covered</p> <p>All billed amounts exceeding the maximum allowed amount*</p> <p>All billed amounts exceeding the maximum allowed amount*</p>
<p>Preventive care / screenings / immunizations</p>	<p>No charge</p>	<p>Not covered</p>
<p>Preventive Care for Chronic Conditions <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>Not covered</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding Lab</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
X-Ray Office Freestanding Radiology Center Outpatient Hospital	10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	Not covered Not covered Not covered
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office <i>Coverage for an Out-of-Network Provider is limited to \$800 maximum per test</i> Freestanding Radiology Center <i>Coverage for an Out-of-Network Provider is limited to \$800 maximum per test</i> Outpatient Hospital <i>Coverage for an Out-of-Network Provider is limited to \$800 maximum per test</i>	10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
<u>Emergency and Urgent Care</u> Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i> Emergency Room Facility Services <i>Your copay will be waived if admitted.</i>	10% coinsurance after deductible is met \$100 copay per visit and 10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount* Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p>Emergency Room Doctor and Other Services</p> <p>Ambulance <i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i></p>	<p>10% coinsurance after deductible is met</p> <p>\$100 copay per trip and 10% coinsurance after deductible is met</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p>Outpatient Mental Health and Substance Use Disorder Services at a Facility</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount*</p> <p>All billed amounts exceeding the maximum allowed amount*</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital <i>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.</i></p> <ul style="list-style-type: none"> 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 <p>Ambulatory Surgical Center <i>Coverage for an Out-of-Network Provider is limited to \$350 maximum per day.</i></p> <p>Physician and other services including surgeon fees</p> <p>Hospital</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount*</p> <p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*</p> <p>All billed amounts exceeding the maximum allowed amount*</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> <i>Anthem's maximum payment is up to \$600 per day for non-emergency Inpatient admissions to Out-of-Network Providers.</i></p> <p>Facility Fees</p> <p>Hip/Knee/Spine Surgeries <i>For inpatient services, this benefit is covered only when performed at a designated Blue Distinction Plus Center for Specialty Care. Subject to utilization review.</i></p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*</p> <p>Not covered</p> <p>All billed amounts exceeding the maximum allowed amount*</p>
<p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Coverage for Out-of-Network Provider is limited to \$150 maximum per day.</i></p>	<p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*</p>
<p>Rehabilitation and Habilitation services</p> <p>Office <i>Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit of physical, occupational or chiropractic care.</i></p> <p>Outpatient Hospital</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Pulmonary rehabilitation <i>office and outpatient hospital</i></p>	<p>10% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount*</p>
<p>Cardiac rehabilitation <i>office and outpatient hospital</i></p>	<p>10% coinsurance after deductible is met</p>	<p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Dialysis/Hemodialysis <i>office and outpatient hospital</i> <i>Coverage for an Out-of-Network Provider is limited to \$350 maximum per visit.</i>	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period. Anthem's maximum payment is up to \$600 per day for non-emergency Inpatient admissions to Out-of-Network Providers.</i>	10% 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	10% coinsurance after deductible is met	Not covered
Prosthetic Devices	10% coinsurance after deductible is met	Not covered
Hearing Aids <i>Coverage is limited to \$700 maximum every 24 Months.</i>	10% 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 services. Other cost shares may apply depending on the 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.
- Outpatient facility tests and treatments done at Ambulatory Surgical Centers or Hemodialysis Centers are limited to a maximum reimbursement of \$350.00 per admission.
- Advanced Diagnostic Imaging is limited to \$800 per service for Out-of-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. Members' 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 (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

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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 alternative 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? Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضاً من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

Farsi

ما، توانیدمی اگر بخوانید؟ را نامه این توانید می آیا :مهم کند کمک شما به آن خواندن در خواهیم شخصی از توانیممی زبان به و کتبی صورت به را نامه این بتوانید است ممکن همچنین با فوراً لطفاً، رایگان کمک دریافت برای. کنید دریافت خودتان تماس (TTY/TDD: 711) 1-888-254-2721 شماره بگیريد.

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721 (TTY/TDD:711) にご連絡ください。

Khmner

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសា របស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយ ឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)

Korean

중요: 이 편지를 읽으실 수 있으신가요?
 그렇지 않으신 경우, 이를 읽으실 수 있도록
 도움을 제공해 드릴 수 있습니다. 귀하의
 모국어로 된 편지를 우편으로 받아보실 수도
 있습니다. 무상으로 제공되는 도움이
 필요하신 경우, 1-888-254-2721번으로 바로
 연락해 주십시오. (TTY/TDD: 711)

Punjabi

ਕੀ ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ
 ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ
 ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ।
 ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ
 ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

Russian

ВАЖНАЯ ИНФОРМАЦИЯ: 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: Mababasa mo ba ang
 sulat na ito? Kung hindi, mayroon kaming
 makakatulong sa iyo na basahin ito.
 Maaari mo ring makuha ang sulat na ito
 nang nakasulat sa iyong wika. Para sa
 libreng tulong, mangyaring tumawag
 kaagad sa 1-888-254-2721.
 (TTY/TDD: 711)

Thai

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่
 หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้
 ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอ
 จดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน
 หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย
 โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721.
 (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có đọc được lá thư
 này không? Nếu không, chúng tôi có thể
 nhờ ai đó giúp quý vị đọc. Quý vị cũng có
 thể yêu cầu thư này viết bằng ngôn ngữ
 của quý vị. Để được trợ giúp miễn phí,
 hãy gọi ngay đến số 1-888-254-2721.
 (TTY/TDD: 711)

It's important we treat you fairly

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to 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. You can also call 1-800-368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Pharmacy Benefit Schedule

PLAN RX 9-35 (HSA \$3400)

	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 \$6,000 Individual / \$12,000 Family

Deductible** \$3,400 Individual / \$6,800 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.

** Deductible applies to both medical and pharmacy benefits. Copays and free generics at Costco apply only after the 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.