Your summary of benefits

Anthem

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: SISC (Self Insured Schools of California): 90-D $10 Anthem Classic PPO

Your Network: Prudent Buyer 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	$10 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$200 person / $500 family	$200 person / $500 family
Overall Out-of-Pocket Limit	$1,000 person / $3,000 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) *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 $10 copay per visit for visits 4+	All billed amounts exceeding the maximum allowed amount*
Mental Health and Substance Use Disorder Services *virtual and office*	$10 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 an Out-of-Network Provider
Specialist Care *virtual and office*	$10 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount*
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	10% 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.*	$10 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.*	10% coinsurance after deductible is met	Not covered
Acupuncture *Coverage is limited to 12 visits per benefit period.*	10% coinsurance after deductible is met	50% of maximum allowed amount*
Other Services in an Office		
Allergy Testing	10% coinsurance after deductible is met	Not covered
Prescription Drugs *Dispensed in the office*	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Surgery	10% 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Diagnostic Services		
Lab		
Office	10% coinsurance after deductible is met	Not covered
Freestanding Lab	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
X-Ray		
Office	10% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office *Coverage for an Out-of-Network Provider is limited to $800 maximum per test*	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Freestanding Radiology Center *Coverage for an Out-of-Network Provider is limited to $800 maximum per test*	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Outpatient Hospital *Coverage for an Out-of-Network Provider is limited to $800 maximum per test*	10% 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 an Out-of-Network Provider
Emergency and Urgent Care		
Urgent Care *includes doctor services.* *Additional charges may apply depending on the care provided.*	$10 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 10% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after deductible is met	Covered as In-Network
Ambulance *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	$100 copay per trip and 10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Doctor Services	10% 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*	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
Ambulatory Surgical Center *Coverage for an Out-of-Network Provider is limited to $350 maximum per day.*	10% 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	10% 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 Out-of-network providers.*		
Facility Fees	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
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.*	10% coinsurance after deductible is met	Not covered
Physician and other services *including surgeon fees*	10% 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 an Out-of-Network Provider is limited to $150 maximum per day.*	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Rehabilitation and Habilitation services Office *Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit of physical, occupational or chiropractic care.*	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pulmonary rehabilitation *office and outpatient hospital*	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Cardiac rehabilitation *office and outpatient hospital*	10% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis *office and outpatient hospital* *Coverage for an Out-of-Network Provider is limited to $350 maximum per visit.*	10% 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*	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.* *Coverage for an Out-of-Network Provider is limited to $600 maximum per day.*	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 *Coverage is limited to $700 maximum every 24 months.*	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.
- 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, Obstetrics/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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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 أيضًا 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

مهم: آیا می توانید این نامه را بخوانید؟ اگر نتوانیدما ، کند کمک شما به آن خواندن در بخواهیم 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 بگیرید.

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។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមទូរស័ព្ទមកស្ថាមប៊ីតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)

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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 ਤੁਸੀ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀ, ਤਾਂ ਅਸੀ 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 เราสามารถขอให้ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอจดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน 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

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SISC
Self-Insured Schools of California
Schools Helping Schools

NAVITUS HEALTH SOLUTIONS

Pharmacy Benefit Schedule

PLAN RX 5-20

	WALK-IN				MAIL	
	Network		Costco		Costco	Navitus
Days' Supply*	30	90	30	90	90	30
Generic	$5	N/A	FREE	FREE	FREE	N/A
Brand	$20	N/A	$20	$50	$50	N/A
Specialty	N/A	N/A	N/A	N/A	N/A	$20

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.