

Your summary of benefits



Anthem® Blue Cross Life and Health Insurance Company

Your Plan: SISC (Self Insured Schools of California): HSA \$5,000 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 after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$5,000 person / \$10,000 family	\$5,000 person / \$10,000 family
Overall Out-of-Pocket Limit	\$6,350 person / \$12,700 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 Non-Network deductibles are combined and accumulate toward each other; however, In-Network and Non-Network out-of-pocket limit amounts accumulate separately 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>	30% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Specialist Care <i>virtual and office</i>	30% 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 a Non-Network Provider
<u>Other Practitioner Visits</u>		
Routine Maternity Care (Prenatal and Postnatal Global Care)	30% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	30% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Manipulation Therapy <i>Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit of physical, occupational or chiropractic care.</i>	30% coinsurance after deductible is met	Not covered
Acupuncture <i>Coverage is limited to 12 visits per benefit period.</i>	30% coinsurance after deductible is met	50% of maximum allowed amount*
<u>Other Services in an Office</u>		
Allergy Testing	30% coinsurance after deductible is met	Not covered
Prescription Drugs <i>Dispensed in the office</i>	30% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Surgery	30% 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 <i>per IRS guidelines</i>	No charge	Not covered
<u>Diagnostic Services</u>		
Lab		
Office	30% coinsurance after deductible is met	Not covered
Freestanding Lab	30% coinsurance after deductible is met	Not covered
Outpatient Hospital	30% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray Office Freestanding Radiology Center Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% 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 a Non-Network Provider is limited to \$800 maximum per test</i> Freestanding Radiology Center <i>Coverage for a Non-Network Provider is limited to \$800 maximum per test</i> Outpatient Hospital <i>Coverage for a Non-Network Provider is limited to \$800 maximum per test</i>	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% 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 Emergency Room Facility Services <i>Your copay will be waived if admitted.</i> Emergency Room Doctor and Other Services Ambulance <i>Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i>	30% coinsurance after deductible is met \$100 copay per visit and 30% coinsurance after deductible is met 30% coinsurance after deductible is met \$100 copay per trip and 30% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount* Covered as In-Network Covered as In-Network Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Mental Health and Substance Use Disorder Services at a Facility Facility Fees Doctor Services	30% coinsurance after deductible is met 30% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount* All billed amounts exceeding the maximum allowed amount*
<u>Outpatient Surgery</u> Facility Fees 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> - 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 Ambulatory Surgical Center <i>Coverage for a Non-Network Provider is limited to \$350 maximum per day.</i> Physician and other services <i>including surgeon fees</i> Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount* All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* All billed amounts exceeding the maximum allowed amount*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<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 Non-Network Providers.</i> Facility Fees	30% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
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>	30% coinsurance after deductible is met	Not covered
Physician and other services <i>including surgeon fees</i>	30% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Home Health Care <i>Coverage is limited to 100 visits per benefit period. Coverage for a Non-Network Provider is limited to \$150 maximum per day.</i>	30% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> Office <i>Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit of physical, occupational or chiropractic care.</i> Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met	Not covered Not covered
Pulmonary rehabilitation <i>office and outpatient hospital</i>	30% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount*
Cardiac rehabilitation <i>office and outpatient hospital</i>	30% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Dialysis/Hemodialysis <i>office and outpatient hospital</i> <i>Coverage for a Non-Network Provider is limited to \$350 maximum per visit.</i>	30% 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>	30% 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 non-network providers.</i>	30% 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	30% coinsurance after deductible is met	Not covered
Prosthetic Devices	30% coinsurance after deductible is met	Not covered
Hearing Aids <i>Coverage is limited to \$700 maximum every 24 months.</i>	30% 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 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.
- 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 (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) 888-8288 or visit us at www.anthem.com/ca

Pharmacy Benefit Schedule

PLAN RX 9-35 5000

	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 \$6,350 Individual / \$12,700 Family

Brand/Specialty Deductible** \$5,000 Individual / \$10,000 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.