Your summary of benefits

Anthem

Anthem® Blue Cross

Your Plan: SISC (Self Insured Schools of California) 80-C $20 Anthem Classic PPO

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$200 person / $500 family	
Out-of-Pocket Limit	$1,000 person / $3,000 family	No limit person / No limit family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum. Fourth quarter deductible carryover applies.		
Preventive Care / Screening / Immunization	No charge	Not covered
Doctor Home and Office Services **Primary Care Visit** *The copay is waived for the first three office visits to a primary care provider per benefit period (See footnote 1)*	$0 copay per visit for visits 1-3, then $20 copay per visit for visits 4+. *(See footnote 1)*	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Specialist Care Visit	$20 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Prenatal and Post-natal Care *The copay is waived for the first three office visits to a primary care provider per benefit period (See footnote 1)*	$20 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Other Practitioner Visits: Retail Health Clinic	$20 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount. (See footnote 2)

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
On-line Visit from LiveHealth Online (LHO) *Includes Mental/Behavioral Health and Substance Abuse*	$10 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Manipulation Therapy *Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit).*	20% coinsurance after deductible is met	Not covered
Acupuncture *Coverage is limited to 12 visits per benefit period.*	20% coinsurance after deductible is met	50% of maximum allowed amount (See footnote 2)
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Dialysis/Hemodialysis *Coverage for a Non-Network Provider is limited to $350 maximum per visit. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Diagnostic Services **Lab:**		
Office	20% coinsurance after deductible is met	Not covered
Freestanding Lab	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% 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
Ultrasounds:		
Office	20% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	20% coinsurance after deductible is met	Not Covered
Outpatient Hospital	20% coinsurance after deductible is met	Not Covered
X-Ray:		
Office	20% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging:		
Office *Coverage for a Non-Network Provider is limited to $800 maximum per test. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Freestanding Radiology Center *Coverage for a Non-Network Provider is limited to $800 maximum per test. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Outpatient Hospital *Coverage for a Non-Network Provider is limited to $800 maximum per test. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care *Office based urgent care.*	$20 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Emergency Room Facility Services *Copay waived if admitted.*	$100 copay per visit and then 20% coinsurance after deductible is met	Covered as In-Network (See footnote 2)
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network (See footnote 2)
Ambulance *Emergency transports.*	$100 copay per trip and then 20% coinsurance after deductible is met	Covered as In-Network (See footnote 2)
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Facility Visit:		
Facility Fees	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Doctor Services	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Services and supplies for the following outpatient surgeries are subject to a benefit limit if performed in an outpatient hospital setting: 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	20% coinsurance up to benefit limit	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Freestanding Surgical Center *Coverage for a Non-Network Provider is limited to $350 maximum per day. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
<u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u>		
Facility Fees *Coverage is limited to $600 benefit maximum per day for non-emergency admission at a Non-Network provider. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
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.	20% coinsurance after deductible is met	Not covered
Doctor and other services	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per benefit period.* *Coverage for a Non-Network Provider is limited to $150 maximum per day. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Rehabilitation services: Office *Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit).* Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	Not covered Not covered
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.* Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met 20% coinsurance after deductible is met	Not covered Not covered
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.* *Coverage for a Non-Network Provider is limited to $600 maximum per day. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Hospice	No charge	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Durable Medical Equipment	20% coinsurance after deductible is met	Not covered
Prosthetic Devices	20% coinsurance after deductible is met	Not covered
Home Infusion Therapy *Coverage for a Non-Network Provider is limited to $600 per day. Subject to utilization review. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
		maximum allowed amount. (See footnote 2 and 3)

Footnote 1: The office visit copay is waived for the first three office visits to a primary care provider 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 providers are defined as General and Family Practitioners, Internists, Gynecologists, Obstetrics/Gynecology, Pediatricians and Nurse Practitioners. The office visit copay will apply to all other provider specialties.

Footnote 2: When using Non-Network PPO Providers, members are responsible for any difference between the maximum allowed amount and actual charges, as well as any deductible & percentage copay.

Footnote 3: The plan may pay for the following services and supplies up to the maximum number of days or visits shown. When using non-network providers, the plan will pay the lesser of the benefit maximum or the maximum allowed amount. If the maximum allowed amount is less than the listed benefit maximum, the plan will not exceed the maximum allowed amount. Likewise, if the listed benefit maximum is less than the maximum allowed amount, the plan will not exceed the listed benefit maximum.

Notes:

- 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.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services” which is generally coinsurance or coinsurance after your deductible is met.
- Other cost shares may apply depending on services provided. Check your Benefit Booklet of Coverage for details.

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 that may apply to the coverage. For more details, important limitations and exclusions, please review the Benefit Booklet. If there is a difference between this summary and the Benefit Booklet, the Benefit Booklet will prevail.

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 alternate 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? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(TTY/TDD:711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

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重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸ ਇਹ ਪੱਤਰ ਪੜਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹ , ਤਾਂ ਅਸ ਇਸ ਨੂੰ ਪੜਹ੍ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਿਖਆ ਹੋਇਆ ਵਬੀ ਪਰ੍ਾਪ ੍ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੈਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. 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: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

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.

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Self-Insured Schools of California (SISC)
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 90-day supply programs. Navitus contracts with most independent and chain pharmacies with the exception of Walgreens.

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

Navi-Gate® for Members allows you to access personalized pharmacy benefit information online at www.navitus.com. For information specific to your plan, visit Navi-Gate® for Members. 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.