Your summary of benefits

Anthem®

Anthem® Blue Cross

Your Plan: SISC (Self Insured Schools of California): High Deductible Plan B (HSA Compatible Classic)

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	$3,000 person / $5,200 family	
Out-of-Pocket Limit	$5,000 person / $10,000 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 per person deductible and per person 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 per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles are combined and accumulate toward each other; however, in-network and out-of-network out-of-pocket maximum amounts accumulate separately and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Mental Health and Substance Use Disorder care	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 a Non-Network Provider
Specialist	10% coinsurance after deductible is met	(See footnote 1) All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	0% coinsurance after deductible is met	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Use Disorder	0% coinsurance after deductible is met	
Specialist Care	10% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Specialist Care	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Other Practitioner Visits		
Retail Health Clinic	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Manipulation Therapy *Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit).*	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 (See footnote 1)

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Services in an Office		
Allergy Testing	10% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Dialysis/Hemodialysis *Coverage for a Non-Network Provider is limited to $350 maximum per visit. (See footnote 2)*	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 1 and 2)
Prescription Drugs *Dispensed in the office*	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Surgery	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office *Coverage for a Non-Network Provider is limited to $800 maximum per test. (See footnote 2)*	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 1 and 2)
Freestanding Radiology Center *Coverage for a Non-Network Provider is limited to $800 maximum per test. (See footnote 2)*	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 1 and 2)
Outpatient Hospital *Coverage for a Non-Network Provider is limited to $800 maximum per test. (See footnote 2)*	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 1 and 2)
Emergency and Urgent Care		
Urgent Care	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Emergency Room Facility Services *Copay waived if admitted.*	$100 copay per visit and then 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	$100 copay per trip and then 10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	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 a Non-Network Provider
		(See footnote 1)
Facility Visit		
Facility Fees	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Doctor Services	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
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. (See footnote 1)
Freestanding Surgical Center *Coverage for a Non-Network Provider is limited to $350 maximum per day. (See footnote 2)*	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 1 and 2)
Doctor and Other Services		
Hospital	10% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 1)

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental Health and Substance Use Disorder) *Coverage is limited to $600 benefit maximum per day for non-emergency admission at a Non-Network provider. (See footnote 2)*		
Facility Fees	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 1 and 2)
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 medical deductible is met	Not Covered
Doctor and other services	10% coinsurance after medical deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
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 2)*	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 1 and 2)
Rehabilitation services		
Office *Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit).*	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	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 a Non-Network Provider
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 2)*	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 1 and 2)
Inpatient Hospice	No charge	All billed amounts exceeding the maximum allowed amount. (See footnote 1)
Durable Medical Equipment	10% coinsurance after deductible is met	Not covered
Prosthetic Devices	10% coinsurance after deductible is met	Not covered
Hearing Aids *Benefit is limited to $700 every 24 months. (See footnote 2)*	10% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 1 and 2)

Footnote 1: 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 2: The plan may pay for the following services and supplies up to the maximum number of days or visits and/or dollar maximum 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:

- 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".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Benefit Booklet for details.
- 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 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.

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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 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

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។ បើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទមកលេខ 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 ਫੋਰਨ 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 โปรดโทรดิดต่อที่หมายเลข 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.

Self-Insured Schools of California (SISC)
Pharmacy Benefit Schedule

PLAN RX 9-35 (HSA B)

	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	$5,000 Individual / $10,000 Family
Deductible:	$3,000 Individual / $5,200 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 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 90day supply programs. Navitus contracts with most independent and chain pharmacies with the exception of Walgreens.

** Deductible applies to medical and pharmacy benefits. Free generics at Costco will only apply after deductible is satisfied.

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.