Your summary of benefits

Anthem

Anthem® Blue Cross

Your Plan: SISC (Self Insured Schools of California): Custom Premier HMO

Your Network: California Care

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

Covered Medical Benefits	Cost if you use an In-Network Provider
Overall Deductible	$0 person
Overall Out-of-Pocket Limit	$1,000 single / $2,000 family
To get benefits under this Plan, you must use In-Network Providers. **Services from Out-of-Network Providers are not covered**, except for Emergency or Urgent Care, Authorized Services, or when required by law. Please be sure to contact us if you are not sure if we have approved an Authorized Service. The family out-of-pocket limit is embedded, meaning each covered person is capped at his or her per single out-of-pocket limit; in addition, cost shares for all covered family members apply to the family out-of-pocket limit, yet no one member will pay more than the per single out-of-pocket limit. All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit.	
Doctor Visits (virtual and office) *Your plan requires the selection of a Primary Care Physician (PCP). A referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services.*	
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$10 copay per visit
Specialist Care *virtual and office*	$10 copay per visit
Other Practitioner Visits	
Maternity services	
Prenatal and Postnatal care	$10 copay per visit
Delivery	No charge
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$10 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Manipulation Therapy *Coverage is limited to 20 visits per benefit period.*	$10 copay per visit
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$10 copay per visit
Other Services in an Office	
Allergy Testing	$10 copay per visit
Prescription Drugs *Dispensed in the office*	$10 copay per visit
Surgery	$10 copay per surgery
Preventive care / screenings / immunizations	No charge
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge
Diagnostic Services **Lab**	
Office	No charge
Freestanding Lab	No charge
Outpatient Hospital	No charge
X-Ray	
Office	No charge
Freestanding Radiology Center	No charge
Outpatient Hospital	No charge
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*	
Office	$100 copay per visit
Freestanding Radiology Center	$100 copay per visit
Outpatient Hospital	$100 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Emergency and Urgent Care	
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	**In-Network and Out-of-Network Providers:** $10 copay per visit
Emergency Room Facility Services *Your copay will be waived if admitted.*	**In-Network and Out-of-Network Providers:** $100 copay per visit
Emergency Room Doctor and Other Services	**In-Network and Out-of-Network Providers:** No charge
Ambulance	**In-Network and Out-of-Network Providers:** $100 copay per trip
Outpatient Mental Health and Substance Use Disorder Services at a Facility	
Facility Fees	No charge
Doctor Services	No charge
Outpatient Surgery	
Facility Fees	
Hospital	No charge
Ambulatory Surgical Center	No charge
Physician and other services *including surgeon fees*	
Hospital	No charge
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)	
Facility Fees	No charge
Physician and other services *including surgeon fees*	No charge
Home Health Care *Coverage is limited to 100 visits per benefit period.*	$10 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 40 visits combined per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.* Office Outpatient Hospital	 $10 copay per visit $10 copay per visit
Pulmonary rehabilitation *office and outpatient hospital*	$10 copay per visit
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	$10 copay per visit
Dialysis/Hemodialysis *office and outpatient hospital*	$10 copay per visit
Chemo/Radiation Therapy *office and outpatient hospital*	$10 copay per visit
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	No charge
Inpatient Hospice	No charge
Durable Medical Equipment	No charge
Prosthetic Devices	No charge

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.
- 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 representations of benefits in this document are subject to California Department of Managed Health Care (DMHC) approval and are subject to change.

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.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental health and substance use disorders. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

Questions: (800) 825-5541 or visit us at http://www.anthe www.anthem.com/ca

Your summary of benefits

Anthem

Anthem® Blue Cross

Your Plan: Chiropractic-Manipulative Treatment/Acupuncture Rider (HMO)

Your Network: ASH

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Benefits described in this section are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California, Inc. (ASH Plans). The services described in this section are covered only if provided by a chiropractor or acupuncturist that is an In-Network Provider. These benefits are in addition to the benefits described in the "Therapy Services" provision within the Evidence of Coverage (EOC). However, when you are treated by a chiropractor or acupuncturist that is an In-Network Provider, services will not be covered other than those benefits specifically described in this section. You may search for chiropractors or acupuncturists that are In-Network Providers using the "Find Care" function on our website at http://www.anthem.com/ca and select the HMO Chiropractic/Acupuncture Network (American Specialty Health Plans).		
Your First Visit You must make an appointment with a chiropractor or acupuncturist that is an In-Network Provider for an examination of your condition. You do not need a referral from your Medical Group or Primary Care Physician to see a chiropractor or acupuncturist that is an In-Network Provider. **Services Must be Approved** All services must be approved as Medically Necessary except for: • An initial new patient exam by a chiropractor or acupuncturists that are In-Network Provider and the provision or commencement, during the initial new patient exam, of Medical Necessary services that are chiropractic and acupuncture services, to the extent services are consistent with professionally recognized, valid, evidence-based standards of practice; and • Emergency Services. If additional services are required after the initial new patient exam and they are approved as Medically Necessary, you are covered up to the maximum number of visits shown below. All visits will be applied towards the maximum number of visits in a Benefit Period. **Services Not Approved** A chiropractor or acupuncturists that is an In-Network Provider may provide non-Covered Services. However, you must agree in writing, before receiving non-Covered Services, to pay for them yourself. If a chiropractor or an acupuncturist that is an In-Network Provider provides non-Covered Services without obtaining your written acknowledgement prior to providing the non-Covered Services, you will not be financially responsible to pay the provider for such non-Covered Services.		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Visits in an Office & Outpatient **Chiropractic Care** *Coverage is limited to 30 visits per benefit period. Benefit limit is for office and outpatient combined. The maximum benefit is for Chiropractic Care Services and Acupuncture Services combined.* **Acupuncture** *Coverage is limited to 30 visits per benefit period. Benefit limit is for office and outpatient combined. Benefit maximum is for Chiropractic Care Services and Acupuncture Services combined.*	$10 copay per visit $10 copay per visit	Not covered Not covered
Diagnostic Services **Lab** **Chiropractic labs** *Covered when prescribed by a chiropractor that is an In-network Provider and approved as Medically Necessary.*	Covered at the same cost share percentage as Diagnostic Labs.	Not covered
Chiropractic X-Ray *Covered when prescribed by a chiropractor that is an In-network Provider and approved as Medically Necessary.*	Covered at the same cost share percentage as Diagnostic X-ray.	Not Covered
Durable Medical Equipment **Chiropractic appliances** *Covered when prescribed by a chiropractor that is an In-Network Provider and approved as Medically Necessary.*	$50 maximum of Chiropractic Appliances per Benefit Period.	Not Covered

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Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

Your summary of benefits

Anthem

Anthem® Blue Cross

Your Plan: Custom Hearing Aid Summary (HMO)

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hearing Aids *Coverage is limited to one hearing aid device per ear every 36 months.*	50% coinsurance	Not Covered
The following hearing aids services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or state-certified audiologist at the above cost share and apply above Member benefit Maximum. • Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under Plan benefits for office visits to Physicians. • Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords, and other ancillary equipment. • Visits for fitting, counseling, adjustments, and repairs for a one-year period after receiving the covered hearing aid. • Includes bone-anchored and FDA approved over-the-counter hearing aids with a prescription. Benefits will not be provided for charges for a hearing aid, which exceeds specifications prescribed for the correction of hearing loss, or for more than the benefit maximums found above and in the Evidence of Coverage (EOC).		

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.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

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 http://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.