Your summary of benefits

Anthem

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: SISC (Self Insured Schools of California): 100-A $0 Anthem Classic PPO Retiree Plan

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	No charge

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$0 person / $0 family	$0 person / $0 family
Overall Out-of-Pocket Limit	$1,000 person / $3,000 family	No limit person / No limit family
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. 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) and Mental Health and Substance Use Disorder Services *virtual and office*	No charge	All billed amounts exceeding the maximum allowed amount*
Specialist Provider *virtual and office*	No charge	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
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	No charge	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.*	No charge	All billed amounts exceeding the maximum allowed amount*
Manipulation Therapy	No charge	Not covered
Acupuncture *Coverage is limited to 12 visits per benefit period.*	No charge	50% of maximum allowed amount
Other Services in an Office		
Allergy Testing	No charge	Not covered
Prescription Drugs *Dispensed in the office*	No charge	All billed amounts exceeding the maximum allowed amount*
Surgery	No charge	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
Diagnostic Services Lab		
Office	No charge	Not covered
Freestanding Lab	No charge	Not covered
Outpatient Hospital	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 X-Ray		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	No charge	Not covered
Diagnostic Services 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*	No charge	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*	No charge	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*	No charge	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	No charge	All billed amounts exceeding the maximum allowed amount*
Emergency Room Facility Services *Your copay will be waived if admitted.*	$100 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	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	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge	All billed amounts exceeding the maximum allowed amount*
Doctor Services	No charge	All billed amounts exceeding the maximum allowed amount*
Outpatient Surgery		
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*	No charge	All billed amounts exceeding the maximum allowed amount*
Ambulatory Surgical Center *Coverage for an Out-of-Network Provider is limited to $350 maximum per day.*	No charge	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Physician and other services *including surgeon fees*	No charge	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
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	No charge	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.*	No charge	All billed amounts exceeding the maximum allowed amount*
Physician and other services *including surgeon fees*	No charge	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.*	No charge	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Therapy Services		
Rehabilitation and Habilitation services		
Office	No charge	Not covered
Outpatient Hospital	No charge	Not covered
Pulmonary rehabilitation *office and outpatient hospital*	No charge	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
Cardiac rehabilitation *office and outpatient hospital*	No charge	Not covered
Dialysis/Hemodialysis *office and outpatient hospital* *Coverage for an Out-of-Network Provider is limited to $350 maximum per visit.*	No charge	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Chemo/Radiation Therapy *office and outpatient hospital*	No charge	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.*	No charge	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*
Additional Services, Equipment and Devices		
Durable Medical Equipment	No charge	Not covered
Prosthetic Devices	No charge	Not covered
Wigs *Coverage for wigs is limited to 1 item after cancer treatment per benefit period* .	No charge	Not covered
Hearing Aids *Coverage is limited to $700 maximum every 24 Months.*	No charge	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.
- Outpatient Facility tests and treatments are limited to $350 per admission for Out-of-Network Providers. Includes: Surgery at Ambulatory Surgical Centers and Hemodialysis.
- 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. 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) 825-5541 or visit us at www.anthem.com/ca/sisc

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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: No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357 (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

Servicios lingüísticos sin costo. Puede solicitar los servicios de un intérprete. También puede solicitar que le leamos y le enviemos algunos documentos en su idioma. Llame al número que figura en su tarjeta de identificación o al 1-888-254-2721. Si necesita más ayuda, llame al Departamento de Seguros de California al 1-800-927-4357 (TTY/TDD: 711).

Arabic

خدمات لغوية مجانية. يمكنك الحصول على مترجم فوري. يمكنك الحصول على مستندات تُقرأ لك وإرسال بعضها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المدرج على بطاقة الهوية الخاصة بك أو 1-800-254-2721. لمزيد من المساعدة اتصل بقسم التأمين في CA على الرقم 1-800-927-4357 (TTY/TDD: 711)

Armenian

Առանց արժեքի լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Դուք կարող եք ստանալ փաստաթղթեր, որոնք կարդում են ձեզ համար, իսկ որոշները՝ ուղարկվում են ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ID քարտում նշված համարով կամ 1-888-254-2721 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք CA Ապահովագրության բաժանմունք՝ 1-800-927-4357 (TTY/TDD՝ 711)

Chinese

免費語言服務。您可獲得口譯員服務。可以把文件唸給您聽，有些文件有您的語言的版本，也可以把這些文件寄給您。欲取得協助，請致電您的 ID 卡所列的電話號碼，或致電 1-888-254-2721 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 (TTY/TDD: 711) 與 CA 保險部聯絡

Farsi

خدمات زبان بدون هزینه. شما می‌توانید مترجم شفاهی درخواست کنید. می‌توانید بخواهید اسناد برای شما به زبان شما خوانده شود و برخی اسناد به زبان شما برایتان ارسال شود. برای راهنمایی، با ما با شماره مندرج در کارت عضویت خود یا شماره 1-888-254-2721 تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه CA به شماره 1-800-927-4357 (TTY/TDD: 711) تماس بگیرید.

Hindi

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ अपनी भाषा में पढ़वा सकते हैं और कुछ को अपनी भाषा में खुद तक भिजवा सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिए गए नंबर पर या 1-888-254-2721 पर हमें कॉल करें। अधिक सहायता के लिए सीए बीमा विभाग को 1-800-927-4357 पर कॉल करें (TTY/TDD: 711)

Hmong

Tsis Sau Nqi Rau Kev Pab Cuam Txog Lus. Koj tuaj yeem tau txais tus kws txhais lus. Koj tuaj yeem tau txais cov ntaub ntawv kom muab nyeem rau koj mloog thiab kom muab xa rau koj ua yam lus koj hais. Rau kev pab, hu peb tus npawb xov tooj muaj nyob ntawm koj daim npav ID los sis 1-888-254-2721. Rau kev pab ntxiv hu lub CA Tuam Tsev Hauj Lwm ntsig txog Kev Tuav Pov Hwm ntawm 1-800-927-4357 (TTY/TDD: 711)

Japanese

無料の言語サービス。通訳を頼むこともできます。文書を使用言語で読み上げたり、送信したりすることもできます。サポートが必要な場合、ID カードに記載されている電話番号または 1-888-254-2721 までお電話ください。さらに詳しい情報については、カリフォルニア州保険局までお問い合わせください。電話番号：1-800-927-4357（TTY/TDD: 711）

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Khmner

មិនគិតថ្លៃសេវាភាសាទេ។ អ្នកអាចទទួលបានអ្នកបកប្រែ។ អ្នកអាចទទួលបានឯកសារអានឱ្យអ្នកស្តាប់ និងឯកសារខ្លះផ្ញើឱ្យអ្នកជាភាសារបស់អ្នក។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងតាមលេខដែលមាននៅក្នុងកាត ID របស់អ្នក ឬ 1-888-254-2721។ សម្រាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅផ្នែកធានារ៉ាប់រង CA តាមរយៈលេខ 1-800-927-4357 (TTY/TDD: 711)

Korean

무상 언어 서비스. 통역사를 연결시켜 드립니다. 문서를 귀하에게 읽어드릴 수 있고 어떤 서류는 귀하의 언어로 작성하여 댁으로 보내드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 나와 있는 번호 또는 1-888-254-2721 번으로 전화해 주시기 바랍니다. 더 많은 도움이 필요하시면 CA 보험부에 1-800-927-4357 (TTY/TDD: 711)로 전화해 주십시오.

Punjabi

ਬਿਨਾ ਕੋਈ ਲਾਗਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਲੈ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੜ੍ਹ ਕੇ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਗਏ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ 1-888-254-2721. ਹੋਰ ਮਦਦ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ 1-800-927-4357 (TTY/TDD: 711)

Russian

Доступны бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Вам могут зачитать документы вслух, а некоторые из них могут быть отправлены вам на вашем языке. Если вам нужна помощь, позвоните нам по номеру, указанному на вашей идентификационной карте участника плана, или по номеру 1-888-254-2721. Для получения дополнительной помощи позвоните в Департамент страхования штата California по номеру 1-800-927-4357 (TTY/TDD: 711)

Tagalog

Walang Gastos na mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter. Maaari mong ipabasa ang mga dokumento sa iyo at ipadala sa iyo ang ilan sa nang nasa wika mo. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o 1-888-254-2721. Para sa higit pang tulong tumawag sa CA Dept. of Insurance sa 1-800-927-4357 (TTY/TDD: 711)

Thai

บริการด้านภาษาแบบไม่เสียค่าใช้จ่าย คุณสามารถรับล่ามเพื่อช่วยเหลือได้ คุณสามารถรับเอกสารแบบมีผู้อ่านให้ฟังและส่งให้คุณในภาษาของคุณได้ หากต้องการความช่วยเหลือ โปรดโทรติดต่อเราตามหมายเลขที่ระบุบนบัตรประจำตัวของคุณหรือ 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดต่อกรมการประกันภัยแห่งแคลิฟอร์เนียได้ที่ 1-800-927-4357 (TTY/TDD: 711)

Vietnamese

Dịch vụ Ngôn ngữ Miễn Phí. Quý vị có thể được bố trí thông dịch viên. Quý vị có thể yêu cầu họ đọc tài liệu hoặc gửi cho quý vị một số tài liệu bằng ngôn ngữ của quý vị. Để được trợ giúp, hãy gọi cho chúng tôi theo số điện thoại được ghi trên thẻ ID của quý vị hoặc 1-888-254-2721. Để được trợ giúp thêm, hãy gọi cho Sở Bảo hiểm CA theo số 1-800-927-4357 (TTY/TDD: 711)

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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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NAVITUS MEDICARERX (PDP) 2026 SUMMARY OF BENEFITS

Self-Insured Schools of California (SISC) – Plan 0X20

This Summary of Benefits explains some of the features of the Navitus MedicareRx Prescription Drug Plan (PDP) for your enrollment in the Self-Insured Schools of California Medicare plan. However, it does not list every benefit, limitation, or exclusion. To get a complete list of your benefits, visit the member portal or contact Navitus MedicareRx Customer Care toll-free at 1-866-270-3877 (TTY users call 711). Calls to these numbers are free. Members can call Customer Care 24 hours a day, seven days a week, except on Thanksgiving and Christmas Day. Potential enrollees, contact your employer group for the materials.

Navitus MedicareRx Member Portal:

- **Current members:** You may access our member portal at www.Medicarerx.navitus.com, click on Members, then Login.

- **New members:** Once you receive your ID card, first time users can register at www.Medicarerx.navitus.com for access to the Member Portal.

Important Contact Information

Navitus MedicareRx Customer Care – 1-866-270-3877 (TTY users call 711). Calls to these numbers are free, and available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Customer Care has free language interpreter services available for non-English speakers.

Pharmacies can also reach Navitus Customer Care 24 hours a day, 7 days a week.

Navitus MedicareRx Member Portal - www.Medicarerx.navitus.com Existing members use this portal to access the most up-to-date formulary and pharmacy directory and to review the materials. Potential enrollees, contact your employer group for a copy of the materials.

Navitus Prescriber Portal – https//prescribers.navitus.com
Your primary care physician or prescribing physician can use this portal to access your Formulary and initiate a Prior Authorization on your behalf.

Navitus Network Pharmacy Portal - https://pharmacies.navitus.com
This portal allows your pharmacy to access the Formulary.

Self-Insured Schools of California (SISC) - For information about plan premiums, eligibility, or enrollment options please contact SISC at 1-661-636-4410.

Centers for Medicare & Medicaid Services (CMS) - CMS is the Federal agency that administers and regulates Medicare. For information on Medicare benefits only (not related to your supplemental/retiree plan), we recommend reviewing CMS's *Medicare & You* booklet. This booklet is mailed out in September to all Medicare households by CMS. You can also sign up to get this handbook electronically at MyMedicare.gov, or order a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Calls to these numbers are free, and you can call 24 hours a day, 7 days a week.

Navitus MedicareRx Summary of Benefits 2026

Part D Prescription Drugs

The benefit information provided summarizes what we cover and what you pay. Your cost sharing may differ based on the pharmacy's status as preferred/non-preferred, mail order, long-term care, home infusion, one-month or extended-day supplies, and what stage of the Medicare Part D benefit you're in. For more information on the additional pharmacy-specific cost-sharing, the stage of the benefit, or a complete description of benefits, please call us or existing members can access the Evidence of Coverage in the member portal.

Yearly Deductible Stage:

This stage does not apply to you because this plan has no deductible for Part D drugs.

Initial Coverage Stage:

During this stage, the plan pays its share of the cost of your drug, and you pay your share of the cost. The table below shows your cost share in each of the plan's drug tiers and shows your payment responsibility until your yearly out-of-pocket drug costs reach $2,100 for Part D covered drugs.

Cost Sharing Tiers	**Network Retail Pharmacy** (1-30 day supply)	**Network Retail Pharmacy** (31-60 day supply)	**Network Retail Pharmacy** (61-90 day supply)	**Network Mail Order Pharmacy** (1-30 day supply)	**Network Mail Order Pharmacy** (31-90 day supply)
Tier 1: Preferred generic and certain low-cost brand products	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 2: Preferred brand and certain higher-cost generic products; includes all specialty products	$20 copayment	$40 copayment	$60 copayment	$20 copayment	$50 copayment
Tier $0 - Certain preventative medications are available for $0 (specific guidelines apply)					

Catastrophic Coverage Stage:
After your yearly out-of-pocket drug costs reach $2,100 for Part D covered drugs, pay $0 cost sharing for the remainder of the coverage year.

Additional Cost Sharing Information

- Your drug copay or coinsurance may be less based on the cost of the drug and the coverage stage you are in.
- Your plan will allow up to a 10-day supply of medication at an out-of-network pharmacy.
- Drugs marked as **NDS** (**N**on-extended **D**ay **S**upply) on the formulary are not available for an extended supply (greater than a one-month supply) at retail, mail-order, or specialty pharmacies.
- If you reside in a long-term care facility, you receive a 31-day supply for a 1-month copay/coinsurance.
- **Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost. Call Customer Care for more information.
- **Important Message About What You Pay for Insulin** - You won't pay more than *$20* for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

For a complete description of benefits, please call Customer Care (numbers on back cover) or existing members can access the Evidence of Coverage on the member portal at www.Medicarerx.navitus.com.

Additional Coverage Information

Your Evidence of Coverage provides more detailed plan information. You can also access these documents on the member portal at www.Medicarerx.navitus.com. You can ask for information regarding the Evidence of Coverage, Formulary and Pharmacy Directory by calling Navitus MedicareRx Customer Care; the number is listed on the back cover.

Additional Help for Medicare called "Extra Help"

Programs are available to help people with low or limited income and resources pay for prescriptions. If you qualify, your Medicare prescription plan costs for your drug costs at the pharmacy and the amount of your premium (there are four different premium levels, and it does not include any Part B premiums) will be less. Once you are enrolled in Navitus MedicareRx, Medicare will tell us how much assistance you will receive and we will send you information on the amount you will pay for your prescriptions.

If you think you may qualify for Medicare's "Extra Help" program, call Social Security 1-800-772-1213 between 8 am and 7 pm, Monday through Friday, to apply for the program. TTY users call 1-800-325-0778. You may also be able to apply at your State Medical Assistance or Medicaid Office. If you qualify for extra help, we have included a letter in your packet called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider." For more information on how to get help with drug plan costs, see Chapter 2, section 7 of the Evidence of Coverage.

Coverage Determination

If your physician prescribes a drug that is not on our drug list, is not a preferred drug, or is subject to additional utilization rules (see below), you may ask us to make a coverage exception. In addition, if Navitus MedicareRx ever denies coverage for your prescriptions, we will explain our decision. You always have the right to appeal our decision or ask us to review the claim denied.

For certain drugs, you or your prescriber need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization.**" Sometimes, the requirement for getting approval in advance helps guide the appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

A requirement to try a different drug first is called "**step therapy.**" Trying a different drug first encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan may cover Drug B.

For certain drugs, you may be limited in the amount of the drug you can have by limiting the quantity of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. A requirement that limits the quantity of a drug you can get filled is called "**quantity limits.**"

Creditable Drug Coverage

Creditable drug coverage is as good as Medicare's standard prescription drug coverage. Creditable coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. A late enrollment penalty is imposed on individuals who do not maintain creditable coverage for any period of 63 days or longer after being first eligible for the Medicare Part D benefit.

Income Related Monthly Adjustment Amount (IRMAA)

If your modified adjusted gross income (MAGI), as reported on your IRS tax return from two years ago, was above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, see Chapter 1, Section 4 of the Evidence of Coverage.

Network Pharmacies

The first step to filling your prescription is deciding on a participating network pharmacy. We have network pharmacies nationwide where you can obtain your prescriptions as a member of our plan. There is a pharmacy search tool and a complete list of network pharmacies on the member portal at www.Medicarerx.navitus.com. To access the pharmacy search tool, click on *Pharmacy Search* on the top navigation bar. You can ask about network pharmacies or request a pharmacy directory mailed to you by calling Navitus MedicareRx Customer Care. The number is listed on the back cover.

In the event of an emergency where you are not able to utilize a network pharmacy, an out-of-network pharmacy may be able to fill your prescription. Your plan will allow up to a 10-day supply of medication at an out-of-network pharmacy.

Recommended Mail Order Pharmacy

Our mail-order service offers an easy way to get up to a 90-day supply of your long-term or maintenance medications. You can use any contracted network mail-order pharmacy you like; currently, the recommended one is Costco Mail Order Pharmacy. You can reach Costco Mail Order Pharmacy by calling 1-800-607-6861 or visiting their website, pharmacy.costco.com.

Using the recommended mail-order pharmacy allows you to have your medications delivered to your home, and in some cases, at a lower rate than if you purchased them at a retail pharmacy.

Note: Costco Mail Order Pharmacy use does not require a Costco Warehouse membership.

Recommended Specialty Pharmacy

You can use any contracted specialty pharmacy you like; however, Navitus recommends Lumicera Specialty Pharmacy for providing the best home-delivery service and rates on specialty drugs. You can contact Lumicera's Customer Care at 1-855-847-3553 (TTY users call 711). The member portal has a pharmacy search tool and a complete list of network pharmacies at www.Medicarerx.navitus.com.

Refilling Prescriptions at a New Pharmacy

If you want to switch to a new pharmacy, automatic prescription refill transfers do not happen. Please give your Navitus ID card to your *new* pharmacy and let them know which pharmacy the prescription refills are located at and the medication names/strengths. Your *new* pharmacy can work with the previous pharmacy to see if these refills can be transferred. Some prescriptions may not be allowed to transfer, and in that case, your prescriber will need to write a new prescription.

Supplemental Coverage

Supplemental Coverage, or Wrap coverage, is provided as part of your prescription benefit. This supplemental coverage may pay for prescription drugs even when Medicare does not cover them. However, you will still be responsible for paying your copayments or coinsurance. The amount you pay when you fill a prescription for these drugs does not count towards the catastrophic coverage stage. In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.

General Information

What will I pay for Navitus MedicareRx premiums?

Your coverage is provided through a contract with your current or former employer. Please contact the SISC for information about your 2026 Part D plan premium.

Where is Navitus MedicareRx available?

The service area for Navitus MedicareRx includes all 50 states, including Puerto Rico, the U.S. Virgin Islands, and Guam. You must live in the service area to join Navitus MedicareRx. If you reside outside the service area, you are not eligible to enroll in Navitus MedicareRx.

Please contact your employer group if you plan to move out of the service area.

It is also important that you call Social Security if you move or change your mailing address. Existing members can find phone numbers and contact information for Social Security in Chapter 2, Section 5 of your Evidence of Coverage (EOC). Potential enrollees, contact your employer group for a copy of the Evidence of Coverage.

Who is eligible to join?

You, your spouse, and dependents are eligible to join if you qualify for your plan's Medicare retiree coverage through Navitus MedicareRx; you are enrolled in Medicare Parts A and B; and live in the service area. Your premium for Medicare Parts A and B must be paid to keep your Medicare Parts A and B coverage and to remain a member of this plan.

How do I know which medications the Navitus MedicareRx Formulary covers?

The Navitus MedicareRx Formulary lists drugs selected to meet patient needs. Navitus MedicareRx may periodically make changes to the Formulary. In the event of CMS-approved non-maintenance changes to the Formulary throughout the plan year, Navitus MedicareRx will notify you.

Does my plan cover Medicare Part B or Part D drugs?

Navitus MedicareRx does not cover drugs covered under Medicare Part B as prescribed and dispensed, although the supplemental coverage benefit provided by SISC will pay secondary to Medicare Part B on select items such as diabetic testing supplies (review the Formulary to confirm coverage). Generally, we only cover drugs, vaccines, biologics, and medical supplies that are covered under the Medicare Prescription Drug Benefit and that are on the Formulary. The drugs on the Drug List (Formulary) are selected by Navitus MedicareRx with the help of a team of doctors and pharmacists. The list must meet specific requirements set by Medicare. Medicare has approved the Navitus MedicareRx Drug List. The supplemental portion of your plan covers some additional drugs that are not typically part of the standard Medicare Part D formulary.

What is a Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a service Navitus MedicareRx offers. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. There is no cost to you to participate in the MTM Program. If you have questions concerning our MTM Program please contact our Navitus MedicareRx Customer Care number on the back cover. For additional information regarding Medication Therapy Management, please refer to Chapter 3, Section 10, of your Evidence of Coverage.

What are my protections in the plan?

All Medicare prescription plans agree to stay in the program for a full year at a time. Each year, your employer group decides whether to continue for another year. If a plan decides not to continue, they must

send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare prescription coverage in your area.

Please call Navitus MedicareRx for more information about this plan

Navitus MedicareRx Customer Care: Toll-free 1-866-270-3877 (TTY users call 711), 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day.

Pharmacies can call Navitus MedicareRx 24 hours a day, 7 days a week.

Navitus MedicareRx Member Portal:

- **Current members:** You may access our member portal by going to www.Medicarerx.navitus.com, click on Members, then Login.
- **New members:** Once you receive your ID card, first time users can register at www.Medicarerx.navitus.com for access to the member portal.
- Potential enrollees, contact your employer group for the materials.

For more information about **Medicare**, call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Calls to these numbers are free and you can call 24 hours a day, 7 days a week. Or visit www.medicare.gov.

Navitus MedicareRx (PDP), offered by Dean Health Insurance, Inc., is a prescription drug plan with a Medicare contract. Enrollment in Navitus MedicareRx depends on contract renewal.