SISC
Self-Insured Schools of California
Schools Helping Schools

A. Schedule of Medical Benefits – HSA-$3,000 Rx HSA-$3,000 Option

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Calendar Year The *network* and *non-network deductible* amounts accumulate towards each other. *Co-insurance* does not apply to the *deductible*.		
Per *plan participant*	$3,000	
Per *family unit*	$5,200	
Family Unit - Embedded Deductible If you are enrolled in the family option, your *Plan* contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*.		
Maximum Out-of-Pocket Limit, per Calendar Year The *out-of-pocket limit* includes *co-insurance*, *deductibles,* and *prescription drugs*. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.		
Per *plan participant*	$5,000	Unlimited
Per *family unit*	$10,000	Unlimited
Family Unit - Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows each member of your *family unit* the opportunity to have their *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.		
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the Plan:** 1. cost containment penalties 2. amounts over *the maximum allowable charges* 3. charges not covered under the *Plan* 4. *balanced billed* charges 5. amounts paid by *plan participants* for *non-network* services		

Benefits shown as *co-payments* and *co-insurance* are listed for what the *plan participant* will pay.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
Acupuncture	10% *co-insurance*, after *deductible*	50% of the maximum allowed amount, after *deductible*.	**Calendar Year Maximum:** twelve (12) visits.
Advanced Imaging	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Non-Network Benefit Maximum:** $800 per test. Includes Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans, excluding services rendered in an emergency room setting. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Allergy Services			
Allergy Testing	10% *co-insurance*, after *deductible*	Not Covered	Serum is included.
Allergy Treatment	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Ambulance Service	$100 *co-payment*/trip then 10% *co-insurance*, after *deductible*		**Benefit Maximum:** $50,000 per trip for non-emergent air ambulance services when performed by a *non-participating provider*. ***Pre-certification* is required for non-emergent air ambulance.** Failure to obtain pre-certification may reduce benefits.
Ambulatory Surgical Center	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Benefit Maximum:** limited to $350 per day for non-emergency admission at a *non-network* provider.

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Applied Behavioral Analysis (ABA) Services			
Testing/Evaluation	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Treatment	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Chemotherapy Drugs/Infusions and Radiation Treatments	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Chiropractic Treatment	10% *co-insurance*, after *deductible*	Not Covered	Covered services are subject to *medical necessity* review in excess of five (5) visits. If the service is *medically necessary*, the service will be automatically authorized.
Diabetic Education	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Diabetic Shoes	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Calendar Year Maximum:** two (2) pairs.
Diagnostic Testing	10% *co-insurance*, after *deductible*	Not Covered	
Dialysis, Outpatient	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Non-Network Benefit Maximum:** $350 per visits. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Durable Medical Equipment	10% *co-insurance*, after *deductible*	Not Covered	***Pre-certification* is required** for *DME* in excess of $1,000 purchase/rental price. Failure to obtain pre-certification may reduce benefits.
Emergency Room	$100 *co-payment*/visit then 10% *co-insurance*, after *deductible*		

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Glasses or Contacts Following Cataract Surgery	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Benefit Maximum:** the first pair of contact lenses or eyeglasses when required as a result of a covered *medically necessary* eye *surgery*.
Hearing Services			
Hearing Aids	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Benefit Maximum:** $700 per *plan participant*, per twenty-four (24) month period. This maximum includes the hearing aids (monaural or binaural), ear mold(s), batteries, cords, and other ancillary equipment. Over-the-counter hearing aids in conjunction with prescription will be covered.
Hearing Exams (Non-Routine)	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	Services include visits for fitting, counseling, adjustments, and repairs for a one (1) year period after receiving covered hearing aids.
Home Health Care	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Calendar Year Visit Maximum:** one hundred (100) visits *network* and *non-network* providers combined. **Non-Network Benefit Maximum:** $150 per day. ***Pre-certification* is required.** Failure to obtain *pre-certification* may reduce benefits.
Home Infusion	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Non-Network Benefit Maximum:** $600 per day. ***Pre-certification* is required.** Failure to obtain *pre-certification* may reduce benefits.
Hospice Care			
Hospice Care	0% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	Respite care limited to five (5) consecutive days per admission.
Bereavement Counseling	0% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Inpatient Hospital			
Physician Visits	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Non-Network Benefit Maximum:** $600 per day. *Inpatient* services and supplies provided for hip replacement, knee replacement, and spine *surgery* must be performed by a designated *Blue Distinction+ (BD+) hospital*. No coverage if *inpatient* services and supplies are provided by a *hospital* that is not designated as *Blue Distinction+ (BD+)*. Please refer to the Schedule of Blue Distinction Center+ (BD+) schedule of benefits for hip replacement, knee replacement, and spine *surgery* services covered under the *Plan*. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Room and Board	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Lab and X-Ray	10% *co-insurance*, after *deductible*	Not Covered	
LiveHealth Online	0% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	Telemedicine benefit provided through Anthem at **www.livehealthonline.com**.
Maternity			
Office Visits	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Non-Network Benefit Maximum:** $600 per day.
All Other Services	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Labor and Delivery	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Mental Disorders & Substance Use Disorder			
Inpatient	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Office Visits	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Outpatient	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	***Pre-certification* is required for certain services within this category.** Failure to obtain pre-certification may reduce benefits.
Partial Hospitalization and Outpatient Intensive Day Treatment	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Office Visit			
Primary Care Physician	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Specialist	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Orthotic Appliances/Foot Orthotics/Prosthetics	10% *co-insurance*, after *deductible*	Not Covered	**Calendar Year Maximum:** two (2) pairs of custom molded orthotics. An additional two (2) pairs will be considered post-*surgery* if *medically necessary*. ***Pre-certification* is required** for orthotics/prosthetics in excess of $1,000 purchase price. Failure to obtain pre-certification may reduce benefits.
Outpatient Surgery	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	The following *outpatient surgeries* are subject to a benefit limit if performed in an *outpatient hospital* setting: **Arthroscopy Benefit Maximum:** $4,500 per procedure. **Cataract Surgery Benefit Maximum:** $2,000 per procedure. **Colonoscopy Benefit Maximum:** $1,500 per procedure. **Upper GI Endoscopy with Biopsy Benefit Maximum:** $1,250 per procedure. **Upper GI Endoscopy without Biopsy Benefit Maximum:** $1,000 per procedure. ***Pre-certification* is required** for *outpatient surgical procedures* Pain management injections in excess of $1,000 performed in an office setting also require *pre-certification*. All other office *surgeries* and screening colonoscopies do not require *pre-certification*. Failure to obtain pre-certification may reduce benefits.
Post Aural Therapy	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Retail Health Clinics	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Routine Newborn Care	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Skilled Nursing Facility/ Extended Care	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Calendar Year Visit Maximum:** one hundred fifty (150) days *network* and *non-network* providers combined. **Non-Network Benefit Maximum:** $600 per day. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Therapy Services			
Physical Therapy Occupational Therapy	10% *co-insurance*, after *deductible*	Not Covered	Following the first five (5) visits, all physical therapy and occupational therapy services are subject to *medical necessity* review. If the service is within the first five (5) visits per *plan participant*, per provider, the service will be automatically authorized.
Speech Therapy	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	
Cardiac Rehabilitation Pulmonary Rehabilitation	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Cardiac Rehabilitation Calendar Year Maximum:** thirty-six (36) visits office and *outpatient* facility visits combined. Following thirty-six (36) visits, additional visits are subject to *medical necessity* review and will be covered under the *Plan* if determined to be *medically necessary*. Cardiac rehabilitation is limited to phase one (1) and phase two (2).
Urgent Care	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE			
Routine Wellness Care	0% *co-insurance*, *deductible* waived	Not Covered	Services include routine physical exam, related labs and x-rays, immunizations, gynecological exam, pap smear, 2D and 3D mammograms, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. **Calendar Year Maximum:** One (1) visit per adult *plan participant*. This maximum does not include the well woman visit. Preventive screening colonoscopies are subject to the dollar maximum as outlined in the Outpatient Surgery benefit if rendered in an *outpatient hospital* setting.
Breastfeeding Pump and Supplies	0% *co-insurance*, *deductible* waived	Not Covered	**Benefit Maximum:** One (1) breast pump per pregnancy. Breastfeeding support, supplies, and counseling. Breast pumps purchased over the counter are not covered.
Contraceptive Services	0% *co-insurance*, *deductible* waived	Not Covered	**Benefit Limitations:** Services are available to all female *plan participants*.

B. Schedule of Blue Distinction Center Benefits

The *Blue Distinction Center* requirement does not apply (services will be covered at the applicable benefit level subject to all other *Plan* provisions) if:

1. *emergency* or urgent *surgery* is *medically necessary* to treat a recent fracture
2. *plan participants* that are under the age of eighteen (18)
3. additional complications are present such as cancer
4. the *plan participant* has primary coverage with *Medicare* or another carrier
5. the *plan participant* lives outside of California

COVERED SERVICES	NETWORK CENTER OF EXCELLENCE/BLUE DISTINCTION CENTER	NETWORK	NON-NETWORK	SPECIAL COMMENTS
Bariatric Surgery	10% *co-insurance*, after *deductible*	Not Covered	Not Covered	**Travel Benefit Maximum**: $3,000 per *surgery* for travel to a *Blue Distinction Center/Center of Excellence* or *Blue Distinction+ (BD+)* only. Limited to three (3) trips maximum – one (1) pre-operative trip, one (1) *surgery* trip, and one (1) post-operative trip if necessary. All other related services will pay at the applicable benefit level. Bariatric surgery services will be covered under the *Plan* at a *Blue Distinction Center/Center of Excellence* or *Blue Distinction+ (BD+) Center*. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Cornea Transplants	10% *co-insurance*, after *deductible*	10% *co-insurance*, after *deductible*	All billed amounts exceeding the maximum allowed amount, after *deductible*.	**Travel Benefit Maximum**: $10,000 per transplant for travel to *Blue Distinction Centers/Centers of Excellence* only. Travel will only be covered under the *Plan* when the *plan participant's* home is fifty (50) miles or more from the nearest *Blue Distinction Center/Center of Excellence*. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
All Other Organ Transplants	10% *co-insurance*, after *deductible*	Not Covered	Not Covered	**Travel Benefit Maximum**: $10,000 per transplant for travel to a *Blue Distinction Center/Center of Excellence* only. Travel will only be covered under the *Plan* when the *plan participant's* home is fifty (50) miles or more from the nearest *Blue Distinction Center/Center of Excellence*. **Donor Search Limitation:** $30,000 per transplant per *plan participant*. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.

C. Schedule of Blue Distinction Center+ (BD+) Benefits

The *Blue Distinction+ (BD+) Center* requirement does not apply if:

1. emergency or urgent *surgery* is *medically necessary* to treat a recent fracture
2. *plan participants* that are under the age of eighteen (18)
3. additional complications are present such as cancer
4. the *plan participant* has primary coverage with *Medicare* or another carrier
5. the *plan participant* lives outside of California

COVERED SERVICES	NETWORK BLUE DISTINCTION+ (BD+) CENTER	ALL OTHER PROVIDERS	SPECIAL COMMENTS
Inpatient Hip Replacement/Knee Replacement/Spine Surgeries	10% *co-insurance*, after *deductible*	Not Covered	**Travel Benefit Maximum**: $6,000 per *surgery*. Travel will only be covered under the *Plan* when the *plan participant's* home is fifty (50) miles or more from the nearest hip replacement/knee replacement/spine *Blue Distinction+ (BD+) Center*. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.

SISC
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NAVITUS HEALTH SOLUTIONS

Pharmacy Benefit

Schedule PLAN RX 9-35

(HSA $3000)

	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 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.