SISC
Self-Insured Schools of California
*Schools Helping Schools*

## A. Schedule of Medical Benefits – PPO 90-G $20 - Rx 7-25 Option

| | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|
| **Deductible, per Calendar Year**<br>The *network* and *non-network deductible* amounts accumulate towards each other.<br>*Co-payments, prescription drugs,* and *co-insurance* do not apply to the *deductible*. | | |
| Per *plan participant* | $500 | |
| Per *family unit* | $1,000 | |
| **Family Unit - Embedded Deductible**<br>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**<br>The *out-of-pocket limit* includes *co-payments, co-insurance,* and *deductibles*.<br>The *network* and *non-network out-of-pocket limits* do not accumulate towards each other. | | |
| Per *plan participant* | $1,000 | Unlimited |
| Per *family unit* | $3,000 | Unlimited |
| **Family Unit - Embedded Out-of-Pocket Limit**<br>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.<br>**NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the Plan:**<br>1. cost containment penalties<br>2. amounts over *the maximum allowable charges*<br>3. charges not covered under the *Plan*<br>4. *balanced billed* charges<br>5. *prescription drugs*<br>6. 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. | 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. | **Calendar Year Maximum:** twelve (12) visits. |
| **Advanced Imaging** | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | **Non-Network Benefit Maximum:** $800 per test.<br>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.<br>***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. | |
| **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*.<br>***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. | **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. | |
| Treatment | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | |
| **Chemotherapy Drugs/Infusions and Radiation Treatments** | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | ***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 a *medical necessity* review performed by ASH Networks. |
| **Diabetic Education** | $20 co-payment/visit | All billed amounts exceeding the maximum allowed amount. | |
| **Diabetic Shoes** | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | **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. | **Non-Network Benefit Maximum:** $350 per visits.<br>***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 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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| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Glasses or Contacts Following Cataract Surgery** | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | **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. | **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. |
| Hearing Exams (Non-Routine) | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | 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. | **Calendar Year Visit Maximum:** one hundred (100) visits *network* and *non-network* providers combined.<br>**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. | **Non-Network Benefit Maximum:** $600 per day.<br>***Pre-certification* is required.** Failure to obtain *pre-certification* may reduce benefits. |
| **Hospice Care** | | | |
| Hospice Care | 0% *co-insurance*, *deductible* waived | All billed amounts exceeding the maximum allowed amount. | Respite care limited to five (5) consecutive days per admission.<br>***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits. |
| Bereavement Counseling | 0% *co-insurance*, *deductible* waived | All billed amounts exceeding the maximum allowed amount. | |

## PPO 90-G $20 - Rx 7-25 Option

| 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. | **Non-Network Benefit Maximum:** $600 per day.<br>*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+)*.<br>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*.<br>***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. | |
| **Lab and X-Ray** | 10% *co-insurance*, after *deductible* | Not Covered | |
| **LiveHealth Online** | | | |
| Effective 1/1/2022 – 9/30/2022 | $10 co-payment/visit | All billed amounts exceeding the maximum allowed amount. | Telemedicine benefit provided through Anthem at **www.livehealthonline.com**. |
| Effective 10/1/2022 | 0% *co-insurance*, *deductible* waived | All billed amounts exceeding the maximum allowed amount. | |

## PPO 90-G $20 - Rx 7-25 Option

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Maternity** | | | |
| Office Visits | ***First Three (3) Visits:** 0% *co-insurance*, *deductible* waived<br>**After Three (3) Visits:** $20 co-payment/visit | All billed amounts exceeding the maximum allowed amount. | **Non-Network Benefit Maximum:** $600 per day.<br>***Limited to three (3) no charge visits all office visits combined. |
| All Other Services | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | |
| Labor and Delivery | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | |
| **Mental Disorders & Substance Use Disorder** | | | |
| Inpatient | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits. |
| Office Visits | ***First Three (3) Visits:** 0% *co-insurance*, *deductible* waived<br>**After Three (3) Visits:** $20 co-payment/visit | All billed amounts exceeding the maximum allowed amount. | ***Limited to three (3) no charge visits all office visits combined. |
| Outpatient | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | ***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. | ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits. |

**PPO 90-G $20 - Rx 7-25 Option**

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Office Visit** | | | |
| Primary Care Physician | ***First Three (3) Visits:** 0% *co-insurance*, *deductible* waived<br>**After Three (3) Visits:** $20 co-payment/visit | All billed amounts exceeding the maximum allowed amount. | The *co-payment* applies to the office visit only. All other services rendered during the *physician's* office visit are paid at the applicable benefit level.<br>***Limited to three (3) no charge visits all office visits combined. |
| Specialist | $20 co-payment/visit | All billed amounts exceeding the maximum allowed amount. | |
| **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*.<br>***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. | The following *outpatient surgeries* are subject to a benefit limit if performed in an *outpatient hospital* setting:<br>**Arthroscopy Benefit Maximum:** $4,500 per procedure.<br>**Cataract Surgery Benefit Maximum:** $2,000 per procedure.<br>**Colonoscopy Benefit Maximum:** $1,500 per procedure.<br>**Upper GI Endoscopy with Biopsy Benefit Maximum:** $1,250 per procedure.<br>**Upper GI Endoscopy without Biopsy Benefit Maximum:** $1,000 per procedure.<br>***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. | |

**PPO 90-G $20 - Rx 7-25 Option**

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Rehabilitation/Habilitation Therapy** | | | |
| Physical Therapy<br>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 a *medical necessity* review performed by ASH Networks. |
| Speech Therapy | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | |
| Cardiac Rehabilitation<br>Pulmonary Rehabilitation | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | **Cardiac Rehabilitation Calendar Year Maximum:** thirty-six (36) visits office and *outpatient* facility visits combined.<br>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*.<br>Cardiac rehabilitation is limited to phase one (1) and phase two (2). |
| **Retail Health Clinics** | $20 *co-payment* / visit | All billed amounts exceeding the maximum allowed amount. | |
| **Routine Newborn Care** | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | |
| **Skilled Nursing Facility/ Extended Care** | 10% *co-insurance*, after *deductible* | All billed amounts exceeding the maximum allowed amount. | **Calendar Year Visit Maximum:** one hundred fifty (150) days *network* and *non-network* providers combined.<br>**Non-Network Benefit Maximum:** $600 per day.<br>***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits. |
| **Urgent Care** | $20 *co-payment* / visit | All billed amounts exceeding the maximum allowed amount. | The *co-payment* applies to the urgent care visit only. All other services rendered during the *physician's* office visit are paid at the applicable benefit level. |

**PPO 90-G $20 - Rx 7-25 Option**

| 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.<br>**Calendar Year Maximum:** One (1) visit per adult *plan participant*. This maximum does not include the well woman visit.<br>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.<br>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
1. *plan participants* that are under the age of eighteen (18)
2. additional complications are present such as cancer
3. the *plan participant* has primary coverage with *Medicare* or another carrier
4. the *plan participant* lives outside of California

| COVERED SERVICES | 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* 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.<br>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* or *Blue Distinction+ (BD+) Center*.<br>***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 | **Travel Benefit Maximum**: $10,000 per transplant for travel to *Blue Distinction Centers* 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*.<br>***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* 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*.<br>**Donor Search Limitation:** $30,000 per transplant per *plan participant*.<br>***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 | BLUE DISTINCTION+ (BD+) CENTER | ALL OTHER PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Hip/Knee/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/knee/spine *Blue Distinction+ (BD+) Center*.<br><br>***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits. |

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

## PLAN RX 7-25

| | Walk-In | | | | Mail | |
|---|---|---|---|---|---|---|
| | Network | | Costco | | Costco | Navitus |
| Days' Supply* | 30 | 90 | 30 | 90 | 90 | 30 |
| Generic | $7 | N/A | **FREE** | **FREE** | **FREE** | N/A |
| Brand | $25 | N/A | $25 | $60 | $60 | N/A |
| Specialty | N/A | N/A | N/A | N/A | N/A | $25 |

| | |
|---|---|
| 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 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.

**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.