Your summary of benefits

SISC
Self-Insured Schools of California
Schools Helping Schools

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: SISC (Self Insured Schools of California): Proactive Care Plan: **Gold**

Your Network: Anthem Prudent Buyer PPO

Effective October 1, 2026

Visits with Virtual Care-Only Providers	Cost if you use an In-Network Provider
Primary Care, and medical services for urgent / acute care	No charge
Mental Health & Substance Use Disorder Services	No charge

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
No Deductible	$0 person / $0 Family	$0 person* / $0 Family*
Overall Out-of-Pocket Limit	$3,000 person / $6,000 family	No limit per person*/ No limit per family*
There is no deductible. The out-of-pocket limit is embedded, meaning the cost shares of one family member will be applied to per person out-of-pocket limit; in addition, amounts for all covered family members apply to the family out-of-pocket limit. No one member will pay more than the per person out-of-pocket limit. All copayments for covered services with in-network providers apply to the out-of-pocket limit. *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)*: **Maximize your Proactive Care benefits when you seek care from a Primary Care Provider (PCP)**		
Primary Care (PCP) *virtual and office* *Primary Care Providers (PCPs) are those without specialty certifications, practicing general pediatrics, internal medicine, family or general practice, or obstetrics and gynecology.*	$0 Copay	All billed amounts exceeding the maximum allowed amount*
Urgent Care	$0 Copay	All billed amounts exceeding the maximum allowed amount*
Mental Health and Substance Use Disorder Services *virtual and office*	$0 Copay	All billed amounts exceeding the maximum allowed amount*
Specialist Care *virtual and office* *Copay applies to the office visit. Additional testing / diagnostic / surgical services are subject to the applicable copay for those services.*	$100 copay	All billed amounts exceeding the maximum allowed amount*

Other Practitioner Visits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Routine Maternity Care *virtual and office* (Prenatal and Postnatal Global Care)	$0 copay	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.*	$0 copay	All billed amounts exceeding the maximum allowed amount*
Manipulation Therapy *Pre-authorization review is required after the 5th visit of physical, occupational, or chiropractic care.*	$0 copay	Not covered
Acupuncture *Limited to 12 visits per calendar year.*	$0 copay	50% of maximum allowed amount*
Other Services in an Office	**Cost if you use an In-Network Provider**	**Cost if you use a Non-Network Provider**
Allergy Testing	$0 PCP/$100 Specialist	Not covered
Prescription Drugs *Dispensed in the office*	$0 PCP/$35 Specialist	All billed amounts exceeding the maximum allowed amount*
Surgery	$0 PCP /$300 Specialist	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	**Cost if you use an In-Network Provider**	**Cost if you use a Non-Network Provider**
Office Lab	$0 copay	Not covered
Freestanding Lab	$0 copay	Not covered
Outpatient Hospital Lab	$150 copay	Not covered
X-Ray	**Cost if you use an In-Network Provider**	**Cost if you use a Non-Network Provider**
Office	$0 copay PCP / $75 specialist	Not covered
Freestanding Radiology Center	$75 copay	Not covered
Outpatient Hospital	$225 copay	Not covered

Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans.* Coverage for a Non-Network Provider is limited to $800 maximum per test.	**Cost if you use an In-Network Provider**	**Cost if you use a Non-Network Provider**
Freestanding Radiology Center	$300 copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.
Outpatient Hospital	$750 copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.
Emergency Care	**Cost if you use an In-Network Provider**	**Cost if you use a Non-Network Provider**
Emergency Room Facility and Doctor Services *Your ER copay will be waived if admitted. Inpatient Hospital copay(s) apply if admitted.*	$700 copay	Covered as In-Network
Emergency - Other Services *Copay applies to visit. Additional testing / diagnostic / surgical services are subject to the applicable copay for those services.*	Applicable outpatient / Inpatient copays	Covered as In-Network
Ambulance *Authorized Non-Network non-emergency ambulance services are limited to a maximum payment of $50,000 per trip.*	$700 (ground or air)	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility	**Cost if you use an In-Network Provider**	**Cost if you use a Non-Network Provider**
Facility Fees *Prior Auth Required*	$0 per day	All billed amounts exceeding the maximum allowed amount*
Doctor Services	Included in per day Facility fee.	All billed amounts exceeding the maximum allowed amount*
Outpatient Procedures	**Cost if you use an In-Network Provider**	**Cost if you use a Non-Network Provider**
Outpatient Procedure at an ASC, including surgeon fees	$600 copay	All billed amounts exceeding the maximum allowed amount*
Outpatient Procedure at a Hospital, including surgeon fees	$1,800 copay	All billed amounts exceeding the maximum allowed amount*
Inpatient Hospital {Including Maternity, Mental Health, and Substance Use Disorder Services} *Coverage for non-emergency inpatient admissions to non-network providers is limited to $600 maximum per day.*	**Cost if you use an In-Network Provider**	**Cost if you use a Non-Network Provider**
Facility Fees	$600 copay per day	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed

		amount*
Hip / Knee / Spine Surgeries *Please refer to Blue Distinction Center Program Travel Benefit. Maximum of $6,000 per surgery is covered if plan participant's home is 50 miles more from nearest hip replacement / knee replacement / spine Blue Distinction Center.* *Carrum Program may provide a $0 cost alternative. Please refer to Carrum Program.*	Included in the $600 per day copay.	Not Covered
Physician and other services *including surgeon fees*	Included in the $600 per day copay.	All billed amounts exceeding the maximum allowed amount
Home Health Care *Limited to 100 visits per calendar year.* *Coverage for a Non-Network Provider is limited to $150 maximum per day.*	$0 copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Rehabilitation and Habilitation Services	**Cost if you use an In-Network Provider**	**Cost if you use a Non-Network Provider**
Office *Limited to 36 office and outpatient visits per calendar year combined.*	$0 copay	Not covered
Outpatient Hospital *Limited to 36 office and outpatient visits per calendar year combined.*	$0 copay	Not covered
Pulmonary rehabilitation *office and outpatient hospital* *Limited to 36 office and outpatient visits per calendar year combined.*	$0 copay	All billed amounts exceeding the maximum allowed amount*
Cardiac rehabilitation *office and outpatient hospital* *Limited to 36 office and outpatient visits per calendar year combined.*	$0 copay	Not covered
Dialysis Hemodialysis *Coverage for a Non-Network Provider is limited to $350 maximum per visit.*	$0 copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*
Chemo/Radiation Therapy	$0 copay	All billed amounts exceeding the maximum allowed amount*
Skilled Nursing Care (facility) *Limited to 150 days per calendar year.*	$1,200 copay per admission	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount*

Inpatient Hospice	$0 copay	All billed amounts exceeding the maximum allowed amount*
Durable Medical Equipment *Pre-certification required for DME in excess of $1,000 purchase / rental price.*	$0 copay	Not covered
Prosthetic Devices	$0 copay	Not covered
Hearing Aids *Limited to $700 per plan participant, per 24-month period.*	$0 copay	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 "Primary Care (PCP) virtual and office," "Specialist Care virtual and office," or "Urgent Care" respectively.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Plan Benefit Booklet 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 Non-Network Providers. Includes: Surgery at Ambulatory Surgical Centers and Hemodialysis.
- Advanced Diagnostic Imaging is limited to $800 per service for Non-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.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Questions: (800) 888-8288 or visit us at www.anthem.com/ca

Intentionally Left Blank

Get help in your language

Notice of Language Assistance

The SISC Proactive Care Plan has Spanish bilingual capabilities through customer service employees. LanguageLine Solutions, which provides interpreters for over 240 languages, is also available to SISC members enrolled on this plan.

Please visit www.languageline.com/interpreting/interpreting-languages for a list of the languages supported. The service is utilized during standard hours of operation. Additionally, Google Translate enables users to change the language of the member portal.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, **HHH** Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

SISC
Self-Insured Schools of California
Schools Helping Schools

NAVITUS HEALTH SOLUTIONS

Pharmacy Benefit Schedule

Proactive Care Plan RX 9-35

	WALK-IN			MAIL	
PHARMACY	NETWORK	COSTCO	COSTCO	COSTCO	NAVITUS
DAYS SUPPLY	30	30	90	90	30
GENERIC	$9	FREE	FREE	FREE	
BRAND	$35	$35	$90	$90	
PREFERRED BRAND (TIER 0)	FREE	FREE	FREE	FREE	
SPECIALTY					$35
OUT-OF-POCKET MAXIMUM	$2,500 INDIVIDUAL / $3,500 FAMILY				
PREFERRED	ON PREFERRED DRUG LIST				
TIER 0 DRUGS WHEN PRESCRIBED BY AN IN-NETWORK PRIMARY CARE PROVIDER (INCL. INTERNAL MEDICINE, GENERAL/FAMILY, PEDIATRICS, AND OBGYN)	$0 FOR THE FOLLOWING MEDICATIONS • Asthma Inhalers like Qvar, Arnuity Ellipta, Albuterol • Diabetic medications like Ozempic, Jardiance, Mounjaro, Rybelsus, Trulicity • Insulins like insulin Lispro, Humalog, Semglee • Anticoagulants like Xarelto, Eliquis • Specialty Medicines like Dupixent, Xolair • Biosimilars like Adalimumab-adaz, Hadlima				

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 **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.