# Your summary of benefits

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: SISC (Self Insured Schools of California): ASCIP 90-70 Standard PPO

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** | $20 copay per visit deductible does not apply |

| Covered Medical Benefits | Cost if you use an In Network Provider | Cost if you use a Non Network Provider |
|---|---|---|
| **Overall Deductible** | $500 person / $1,000 family | $500 person / $1,000 family |
| **Overall Out-of-Pocket Limit** | $1,000 person / $2,000 family | $3,000 person / $6,000 family |
| The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.<br>All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit.<br>In-Network and Non-Network deductibles are combined and accumulate toward each other; however In-Network and Non-Network out-of-pocket limit amounts accumulate separately and do not accumulate toward each other.<br>*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)** *virtual and office*<br>*The copay is waived for the first three office visits to a primary care provider per benefit period.* | $0 copay per visit for visits 1-3, then $20 copay per visit for visits 4+ | 30% coinsurance after deductible is met* |
| **Mental Health and Substance Use Disorder Services** *virtual and office* | $20 copay per visit deductible does not apply | 30% coinsurance after deductible is met* |

| Covered Medical Benefits | Cost if you use an In Network Provider | Cost if you use a Non Network Provider |
|---|---|---|
| **Specialist Care** *virtual and office* | $20 copay per visit deductible does not apply | 30% coinsurance after deductible is met* |
| **Other Practitioner Visits** | | |
| **Routine Maternity Care** (Prenatal and Postnatal Global Care) | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | $20 copay per visit deductible does not apply | 30% coinsurance after deductible is met* |
| **Manipulation Therapy** *Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit of physical, occupational or chiropractic care.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **Acupuncture** *Coverage is limited to 12 visits per benefit period.* | $20 copay per visit deductible does not apply | 30% coinsurance after deductible is met* |
| **Other Services in an Office** | | |
| **Allergy Testing** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **Prescription Drugs** *Dispensed in the office* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **Surgery** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **Preventive care / screenings / immunizations** | No charge | Not covered |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge | Not covered |
| **Diagnostic Services** | | |
| **Lab** | | |
| Office | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| Freestanding Lab | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| Outpatient Hospital | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **X-Ray** | | |
| Office | 10% coinsurance after deductible is met | 30% coinsurance after |
| Freestanding Radiology Center | 10% coinsurance after deductible is met | 30% coinsurance after |

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|---|---|---|
| Outpatient Hospital | | 30% coinsurance after deductible is met* |
| **Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| Office<br>*Coverage for a Non-Network Provider is limited to $800 maximum per test* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met and all billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| Freestanding Radiology Center<br>*Coverage for a Non-Network Provider is limited to $800 maximum per test* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met and all billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| Outpatient Hospital<br>*Coverage for a Non-Network Provider is limited to $800 maximum per test* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met and 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.* | $20 copay per visit deductible does not apply | 30% coinsurance after deductible is met* |
| **Emergency Room Facility Services**<br>*Your copay will be waived if admitted.* | $50 copay per visit and 10% coinsurance after deductible is met | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | 10% coinsurance after deductible is met | Covered as In-Network |
| **Ambulance**<br>*Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.* | 10% coinsurance after deductible is met | Covered as In-Network |

| Covered Medical Benefits | Cost if you use an In Network Provider | Cost if you use a Non Network Provider |
|---|---|---|
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| Facility Fees | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| Doctor Services | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **<u>Outpatient Surgery</u>** | | |
| **Facility Fees** | | |
| Hospital<br>*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.*<br>o *Arthroscopy limited to $4,500 per procedure*<br>o *Cataract surgery limited to $2,000 per procedure*<br>o *Colonoscopy limited to $1,500 per procedure*<br>o *Upper GI Endoscopy limited to $1,000 per procedure*<br>o *Upper GI Endoscopy with biopsy limited to $1,250 per procedure* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| Ambulatory Surgical Center<br>*Coverage for a Non-Network Provider is limited to $350 maximum per day.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met and all billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| **Physician and other services** *including surgeon fees* | | |
| Hospital | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u>**<br>*Anthem's maximum payment is up to $1,500 benefit maximum per day for non-emergency admission at a Non-Network provider.* | | |
| **Facility Fees** | 10% coinsurance after deductible is met | $250 copay per admission and then 30% coinsurance after deductible is met and all billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |

| Covered Medical Benefits | Cost if you use an In Network Provider | Cost if you use a Non Network Provider |
|---|---|---|
| **Hip/Knee/Spine Surgeries**<br>*For inpatient services, this benefit is covered only when performed at a designated Blue Distinction Plus Center for Specialty Care. Subject to utilization review.* | 10% coinsurance after deductible is met | Not covered |
| **Physician and other services** *including surgeon fees* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **Home Health Care**<br>*Coverage is limited to 100 visits per benefit period.*<br>*Coverage for a Non-Network Provider is limited to $150 maximum per day.* | 10% coinsurance after deductible is met | 10% coinsurance after deductible is met and all billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.* | | |
| Office<br>*Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit of physical, occupational or chiropractic care.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| Outpatient Hospital | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **Pulmonary rehabilitation** *office and outpatient hospital* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **Cardiac rehabilitation** *office and outpatient hospital* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **Dialysis/Hemodialysis** *office and outpatient hospital*<br>*Coverage for a Non-Network Provider is limited to $350 maximum per visit.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met and all billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Skilled Nursing Care (facility)**<br>*Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.* | 10% coinsurance after deductible is met | 10% coinsurance after deductible is met and all billed amounts exceeding the lesser of |

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|---|---|---|
| | | the benefit maximum or maximum allowed amount* |
| **Inpatient Hospice** | No charge | 30% coinsurance after deductible is met* |
| **Durable Medical Equipment** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **Prosthetic Devices** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met* |
| **Hearing Aids**<br>*Coverage is limited to $2,000 maximum every 36 months.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met and 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 Non-Network Providers. Includes: Surgery; 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.
- The office visit copay is waived for the first three office visits to a Primary Care Physician per benefit period. The copay waiver applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible. Primary Care Physician is defined as General and Family Practitioner, Internist, Gynecologist, Obstetric/Gynecology, Pediatrician and Nurse Practitioner. The office visit copay will apply to all other provider specialties.

*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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