blue of california

Self-Insured Schools of California
Effective October 1, 2020
PPO Plan

Summary of Benefits

100% Plan A $0 Copayment

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.[1] Please read both documents carefully for details.

Medical Provider Network: **Full PPO Network**

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Claims Administrator pays for Covered Services under the Plan.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual
		$0: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$1,000
Family coverage	$1,000: individual
	$3,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services.

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		Not covered	
Physician services				
Primary care office visit	$0		50%	
Specialist care office visit	$0		50%	
Physician home visit	$0		50%	
Physician or surgeon services in an outpatient facility	$0		50%	
Physician or surgeon services in an inpatient facility	$0		50%	
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$0		50%	
Acupuncture services *Up to 12 visits per Member, per Calendar Year.*	$0		50%	
Chiropractic services *Up to 20 visits per Member, per Calendar Year.*	$0		Not covered	
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive	$0		Not covered	
• Diaphragm fitting	$0		Not covered	
• Intrauterine device (IUD)	$0		Not covered	
• Insertion and/or removal of intrauterine device (IUD)	$0		Not covered	
• Implantable contraceptive	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	$0		Not covered	
• Diagnosis and Treatment of the Cause of Infertility	Not covered		Not covered	
Podiatric services	$0		50%	
Pregnancy and maternity care[7]				
Physician office visits: prenatal and postnatal	$0		50%	
Physician services for pregnancy termination	$0		Not covered	
Certified nurse midwives	$0		$0	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Emergency services				
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	$100/visit		$100/visit	
Emergency room Physician services	$0		$0	
Urgent care center services	$0		50%	
Ambulance services *This payment is for emergency or authorized transport.*	$100/transport		$100/transport	
Outpatient facility services				
Ambulatory Surgery Center	$0		All charges above $350	
Outpatient Department of a Hospital: surgery	$0		All charges above $350	
Arthroscopy[8]	All charges above $4,500/procedure		Not covered	
Cataract Surgery[8]	All charges above $2,000/procedure		Not covered	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0		50% of up to $350/day plus 100% of additional charges	
Inpatient facility services				
Hospital services and stay	$0		All charges above $600	
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*				
• Special transplant facility inpatient services	$0		Not covered	
• Physician inpatient services	$0		Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Transplant Travel Benefit: Maximum payment will not exceed $10,000 per transplant, (not per lifetime) Ground transportation to and from the Center of Excellence (COE) when the desig-nated COE is 75 miles or more from the recipi-ent's or donor's place of residence. Coach air-fare to and from the COE when the designated COE is 300 miles or more from the recipient's or donor's residence.	All charges above $10,000/ transplant		Not covered	
Bariatric surgery services, designated California counties				
This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the outpatient facility services and Outpatient Physician services payments apply.				
Inpatient facility services	$0		Not covered	
Outpatient facility services	$0		Not covered	
Physician services	$0		Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	$0		Not covered	
• Outpatient Department of a Hospital	$0		Not covered	
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	$0		Not covered	
• Outpatient Department of a Hospital	$0		Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Other outpatient diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*				
• Office location	$0		Not covered	
• Outpatient Department of a Hospital	$0		Not covered	
Radiological and nuclear imaging services				
• Outpatient radiology center	$0		50%	
• Outpatient Department of a Hospital	$0		50% of up to $350/day plus 100% of additional charges	
Colonoscopy[8]	All charges above $1,500/procedure		Not covered	
Upper GI Endoscopy[8]	All charges above $1,000/procedure		Not covered	
Upper GI Endoscopy with Biopsy[8]	All charges above $1,250/procedure		Not covered	
Rehabilitative and Habilitative Services *Includes Physical Therapy, Occupational Therapy, and Respiratory Therapy.*				
Office location	$0		Not covered	
Outpatient Department of a Hospital	$0		Not covered	
Speech Therapy services				
Office location	$0		50%	
Outpatient Department of a Hospital	$0		50%	
Durable medical equipment (DME)				
DME	$0		Not covered	
Breast pump	$0		Not covered	
Orthotic equipment and devices *Up to 2 pairs of shoes and 2 inserts for therapeutic shoes per Calendar Year. Additional 2 pair of orthotics allowed post-surgery*	$0		Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Prosthetic equipment and devices	$0		50%	
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	$0		Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs and medical supplies.*	$0		Not covered	
Home visits by an infusion nurse	$0		Not covered	
Hemophilia home infusion services *Includes blood factor products.*	$0		Not covered	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*				
Freestanding SNF	$0		$0	
Hospital-based SNF	$0		All charges above $600	
Hospice program services				
Pre-Hospice consultation	$0		Not covered	
Routine home care	$0		Not covered	
24-hour continuous home care	$0		Not covered	
Short-term inpatient care for pain and symptom management	$0		Not covered	
Inpatient respite care	$0		Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	$0		50%	
• Self-management training	$0		50%	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Dialysis services	$0		50% of up to $350/day plus 100% of additional charges	
PKU product formulas and Special Food Products	$0		Not covered	
Allergy serum billed separately from an office visit	$0		50%	
Hearing services				
• Hearing aids and equipment *Up to $700 combined maximum per Member, per 24 months.*	$0		$0	
• Audiological evaluations	$0		50%	

Mental Health and Substance Use Disorder Benefits	Your payment			
	When using a Participating Provider or MHSA Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider or MHSA Non-Participating Provider[4, 9]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$0		50%	
Intensive outpatient care	$0		50%	
Behavioral Health Treatment in an office setting	$0		50%	
Behavioral Health Treatment in home or other non-institutional setting	$0		50%	
Office-based opioid treatment	$0		50%	
Partial Hospitalization Program	$0		50% of up to $350/day plus 100% of additional charges	
Psychological Testing	$0		50%	
Inpatient services				
Physician inpatient services	$0		50%	
Hospital services	$0		All charges above $600	
Residential Care	$0		All charges above $600	

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits
- Inpatient facility services
- Hospice program services

Please review the Benefit Booklet for more about Benefits that require prior authorization.

Notes

1 Benefit Booklet:

The Benefit Booklet describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

Capitalized terms are defined in the Benefit Booklet. Refer to the Benefit Booklet for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before the Claims Administrator pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Any charges above the specified Benefit maximum are not covered, do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount, or
- any charges above the stated dollar amount, which is the Benefit maximum.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.

Notes

- Charges above the Allowable Amount or Benefit maximum do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

- Some Benefits from Non-Participating Providers have the Allowable Amount or Benefit maximum listed in the Benefits chart as a specific dollar ($) amount. You are responsible for any charges above the Allowable Amount or Benefit maximum, whether or not an amount is listed in the Benefits chart.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

This Plan has a combined Participating Provider and Non-Participating Provider OOPM. However, only the following Non-Participating Provider services will accrue to the combined OOPM:

- Ambulance services; and
- Emergency services.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

8 Outpatient Facility Services

Services and supplies for the following Outpatient surgeries are subject to a Benefit maximum if performed in the Outpatient department of a Hospital: athroscopy, cataract surgery, colonoscopy, upper GI endoscopy, and upper GI endoscopy with biopsy. The Benefit maximum does not apply when the same services are provided in a participating Ambulatory Surgery Center.

9 For Services by Non-Preferred, Non-Participating and MHSA Non-Participating Providers:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

You are responsible for all charges above the Allowable Amount. However, if the Non-Preferred/Non-Participating/MHSA Non-Participating Provider is a Hospital based Physician performing Services at a Participating/MHSA Participating Provider (in-network) facility; or out of network lab services, when performed by an in-network (participating)

provider, but sent to a non-participating provider for processing, the Claims Administrator's payment will be made at the Participating Provider copayment level.

Authorized Referrals for Services by Non-Preferred/Non-Participating//MHSA Non-Participating Providers –

In some circumstances, the Claims Administrator may authorize participating provider cost share amounts (Deductibles or Co-Payments, if applicable) to apply to a claim for a covered service you receive from a non-participating provider. In such circumstance, you or your physician must contact the Claims Administrator in advance of obtaining the covered service. It is your responsibility to ensure that the Claims Administrator has been contacted. If the Claims Administrator authorizes a participating provider cost share amount to apply to a covered service received from a non-participating provider, you also may still be liable for the difference between the maximum allowed amount and the non-participating provider's charge. Please call the customer service telephone number on the back of your ID card for authorized referral information or to request authorization.

Authorized referral occurs when you, because of your medical needs, are referred to a non-participating provider, but only when:

a. There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence;
b. You are referred in writing to the non-participating provider by the physician who is a participating provider, and
c. The referral has been authorized by the Claims Administrator before services are rendered. You or your physi-cian must call the toll-free telephone number printed on the back of your identification card prior to scheduling an admission to, or receiving the services of, a non-participating provider. Such authorized referrals are not available for transplant and bariatric surgical services. These services are only covered when performed at a COE.

Plans may be modified to ensure compliance with Federal requirements.
LG031820

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

Navitus MedicareRx (PDP) Summary of Benefits 2020

Part D Prescription Drugs

The benefit information provided is a summary of what we cover and what you pay. Your cost sharing may differ based on the pharmacy's status as network/out-of-network; mail order; long term care; home infusion; 30 or 90-day supplies; and when you enter another phase of the Medicare Part D benefit. For more information on the additional pharmacy specific cost-sharing, the phases of the benefit, or a complete description of benefits, please call us or access your Evidence of Coverage online at https://medicarerx.navitus.com.

Yearly Deductible Stage:

Because this plan does not have a deductible for Part D drugs, this payment stage does not apply to you.

Initial Coverage Stage:

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. The table below shows your share of the cost for drugs in each of the plan's drug tiers. You stay in this stage until your total drug costs reach $4,020, when you move on to the Gap Coverage stage.

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 lower-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

Gap Coverage Stage:

During this stage, your employer group benefit will continue to cover your drug costs when the Medicare plan does not; you will be responsible for your copayment/coinsurance if applicable. Your drug copay or coinsurance may be less, based upon the cost of the drug. After your yearly total drug costs reach $6,350 for Part D drugs, you move on to the Catastrophic Coverage Stage.

Catastrophic Coverage Stage:

After your yearly out-of-pocket drug costs reach $6,350 for Part D drugs, you pay the greater of:

Either 5% coinsurance or a $3.60 copay for generic (including brand drugs treated as generic) and a $8.95 copay for all other drugs.

-OR- Your formulary cost sharing tier amount if lesser.

Additional Cost Sharing Information

- Your drug copay or coinsurance may be less, based upon the cost of the drug and the coverage stage you are in.
- If you reside in a long-term care facility, you pay the same for a 31-day supply as a 30-day supply at a retail pharmacy
- Your plan will allow up to a 10-day supply of medication at an out-of-network pharmacy.
- Drugs marked as **NDS** on the formulary are not available for an extended supply (greater than 30-days) at a retail or specialty pharmacy.

For a complete description of benefits, please call Customer Care (numbers on back cover) or access our Evidence of Coverage online at https://medicarerx.navitus.com.