

# Your summary of benefits



Anthem® Blue Cross

Your Plan: SISC (Self Insured Schools of California): Custom Premier HMO

Your Network: California Care

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$0 person	Not covered
<b>Out-of-Pocket Limit</b>	\$1,000 single / \$2,000 family	Not covered
<p>The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	Not covered
<b><u>Doctor Home and Office Services</u></b>		
<b>Primary Care Visit</b>	\$10 copay per visit	Not covered
<b>Specialist Care Visit</b>	\$10 copay per visit	Not covered
<b>Prenatal and Post-natal Care</b>	\$10 copay per visit	Not covered
<b><u>Other Practitioner Visits:</u></b>		
Retail Health Clinic	\$10 copay per visit	Not covered
Preferred On-line Visit by LiveHealth Online (LHO) <i>Includes Mental/Behavioral Health and Substance Abuse</i>	\$10 copay per visit	Not covered
Manipulation Therapy <i>Coverage is limited to 10 visits per benefit period.</i>	\$10 copay per visit	Not covered
Acupuncture <i>Coverage is limited to 10 visits per benefit period.</i>	\$10 copay per visit	Not covered

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Questions: (855) 333-5730 or visit us at [www.anthem.com/ca](http://www.anthem.com/ca)

CA/LG/SISC (Self Insured Schools of California) Custom Premier HMO//10-01-1021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Other Services in an Office:</u></b></p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy</p> <p>Dialysis/Hemodialysis</p> <p>Prescription Drugs - <i>Dispensed in the office</i></p>	<p>\$10 copay per visit</p> <p>\$10 copay per visit</p> <p>\$10 copay per visit</p> <p>\$10 copay per visit</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab:</b></p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>X-Ray:</b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>Advanced Diagnostic Imaging:</b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>\$100 copay per test</p> <p>\$100 copay per test</p> <p>\$100 copay per test</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b> <i>Copay waived if admitted.</i></p>	\$10 copay per visit	Covered as In-Network
<p><b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p>	\$100 copay per visit	Covered as In-Network
<p><b><u>Ambulance</u></b></p>	\$100 copay per trip	Covered as In-Network
<p><b><u>Outpatient Mental/Behavioral Health and Substance Abuse</u></b></p> <p><b>Doctor Office Visit</b></p> <p><b>Facility Visit:</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	\$10 copay per visit	Not covered
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees:</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and Other Services:</b></p> <p>Hospital</p>	No charge	Not covered
<p><b><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></b></p> <p><b>Facility Fees</b></p>	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Doctor and other services</b>	No charge	Not covered
<b><u>Recovery &amp; Rehabilitation</u></b>		
<b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period.</i>	\$10 copay per visit	Not covered
<b>Rehabilitation services:</b>		
Office <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 10 visits per benefit period Coverage for speech therapy is limited to 10 visits per benefit period.</i>	\$10 copay per visit	Not covered
Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 10 visits per benefit period Coverage for speech therapy is limited to 10 visits per benefit period.</i>	\$10 copay per visit	Not covered
<b>Cardiac rehabilitation</b>		
Office <i>Coverage is limited to 36 visits per benefit period.</i>	\$10 copay per visit	Not covered
Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period.</i>	\$10 copay per visit	Not covered
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	No charge	Not covered
<b>Hospice</b>	No charge	Not covered
<b>Durable Medical Equipment</b>	No charge	Not covered
<b>Prosthetic Devices</b>	No charge	Not covered

*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 HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN*

*services received within the member's medical group/IPA, and services for mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.*

**Notes:**

- 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.
- If you have a 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” which is generally coinsurance or coinsurance after your deductible is met. Costs may also vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

# Get help in your language

## Language Assistance Services



Curious to know what all this says? We would be too. Here's the English version:

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

### Spanish

**IMPORTANTE:** ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

### Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD: 711).

### Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

### Chinese

**重要事項:** 您能看懂這封信函嗎? 如果您看不懂, 我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助, 請立即撥打1-888-254-2721。(TTY/TDD: 711)

### Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

### Hindi

**महत्वपूर्ण:** क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

### Hmong

**TSEEM CEEB:** Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

### Japanese

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重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。  
1-888-254-2721 (TTY/TDD: 711)

**Khmer**  
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យមនុស្សម្នាក់អានជូនអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសរសេរជាភាសាអង់គ្លេសផងដែរ។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

**Korean**  
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

**Punjabi**  
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਕੇ ਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸਾਇੰਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿੱਚ ਿਲਿਖਿਆ ਹੋਇਆ ਵਜ਼ੀ ਪਰ੍ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੋਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

**Russian**  
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

**Tagalog**  
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

**Thai**  
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

**Vietnamese**  
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

### 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 27101, Mail Drop VA1002-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 100 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 10101 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>.

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# Chiropractic Care and Acupuncture Rider Plan 10/30

The benefits described in this Rider are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California (ASH Plans). The services listed below are covered only if provided by an ASH Plans Chiropractor and/or ASH Plans Acupuncturist. These benefits are provided in addition to the benefits described in the Anthem Blue Cross HMO Evidence of Coverage (EOC) document. However, when expenses are incurred for treatment received from an ASH Plans Chiropractor or ASH Plans Acupuncturist, no other benefits other than the benefits described in this Rider will be paid.

Covered Services	Member's Copayment
<b>Office Visit to a Chiropractor or Acupuncturist</b>	\$10/visit
<b>Maximum Benefits</b>	
Office visits to a Chiropractor or Acupuncturist	30 visits per calendar year (chiropractic and acupuncture visits combined)
Chiropractic appliances	\$50 per calendar year

### Covered Services

**Chiropractor Services:** Member has up to 30 visits, combined with visits for acupuncture services, in a calendar year for chiropractor care services that are determined by ASH PLANS to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans chiropractor to determine the appropriateness of chiropractic services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans chiropractor
- An established patient exam performed by an ASH Plans chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans chiropractor.
- Radiological x-rays and laboratory tests when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered services include radiological consultations when determined by ASH Plans to be medically/clinically necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Plans to provide those services.
- **Chiropractic Appliances:** Up to \$50 per calendar year when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered chiropractic appliances are limited to:
  - elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports;
  - cervical collars or cervical pillows;
  - ankle braces, knee braces, or wrist braces;
  - heel lifts;
  - hot or cold packs;
  - lumbar cushions;
  - rib belts or orthotics; and
  - home traction units for treatment of the cervical or lumbar regions.

**Acupuncture Services.** Member has up to 30 visits, combined with visits for chiropractic care, in a calendar year for acupuncture services that are determined by ASH Plans to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans acupuncturist is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans acupuncturist to determine the appropriateness of acupuncture services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans acupuncturist
- An established patient exam performed by an ASH Plans acupuncturist to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans acupuncturist.



# Chiropractic Care and Acupuncture Rider Exclusions & Limitations

**Care Not Approved:** Any services provided by an ASH Plans chiropractor or an ASH Plans acupuncturist that are not approved by ASH Plans except as specified as covered in the Evidence of Coverage (EOC). An ASH Plans chiropractor or ASH Plans acupuncturist is responsible for submitting a treatment plan to ASH Plans for prior approval.

**Care Not Covered:** In addition to any service or supply specifically excluded in the EOC, no benefits will be provided for chiropractic or acupuncture services or supplies in connection with:

- Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans. Diagnostic services for acupuncture.
- Thermography.
- Hypnotherapy.
- Behavior training.
- Sleep therapy.
- Weight programs.
- Any non-medical program or service.
- Pre-employment examinations, any chiropractic or acupuncture services required by an employer that are not medically/clinically necessary, or vocational rehabilitation.
- Services and/or treatments which are not documented as medically/clinically necessary.
- Massage therapy.
- Acupuncture performed with reusable needles.
- Acupuncture services benefits are not provided for magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
- Any service or supply for the exam and/or treatment by an ASH chiropractor for conditions other than those related to neuromusculoskeletal disorders.
- Services from an ASH Plans acupuncturist for exam and/or treatment for conditions not related to neuromusculoskeletal disorders, nausea or pain, including, without limitation, asthma or addictions such as nicotine addiction.
- Transportation costs including local ambulance charges.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services;

- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephone compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.
- Laboratory and diagnostic x-ray studies, except as specified as covered in the EOC.

**Non-ASH Plans Chiropractors or non-ASH Plans Acupuncturists:** Services and supplies provided by a chiropractor or an acupuncturist who does not have an agreement with ASH Plans to provide covered services under this plan.

**Work Related:** Care for health problems that are work-related if such health problems are covered by workers' compensation, an employer's liability law or similar law. We will provide care for a work-related health problem, but we have the right to be paid back for that care as described in the EOC.

**Government Treatment:** Any services actually given to the member by a local, state or federal government agency, except when this plan's benefits, must be provided by law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

**Drugs:** Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription.

**Supplement.** Vitamins, minerals, dietary and nutritional supplements or other similar products and any herbal supplements.

**Air Conditioners:** Air purifiers, air conditioners, humidifiers, supplies or any other similar devices or appliances. All appliances or durable medical equipment, except as specified as covered in the EOC..

**Personal Items:** Any supplies for comfort, hygiene or beauty purposes, including therapeutic mattresses.

**Out-Of-Area and Emergency Care:** Out-of-area care is not covered under this Chiropractic and Acupuncture Care benefit, except for emergency services. The member should follow the procedures specified by their Anthem Blue Cross HMO plan to obtain emergency or out-of-area care.

## Third Party Liability

Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

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# Hearing Aid Rider

This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

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## What Is Covered

### Hearing Aid Services

This benefit covers one medically necessary hearing aid, per ear, every three years when ordered by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist. The member is responsible for **50%** coinsurance. Member coinsurance is included in the annual out of pocket max.

Covered services include:

- Audiological evaluations to:
  - measure the extent of hearing loss; and
  - determine the most appropriate make and model of hearing aid.

These evaluations will be covered under the plan benefits for office visits to doctors.

- Hearing aids (monaural or binaural) including:
  - ear mold(s), the hearing aid instrument; and
  - batteries, cords and other ancillary equipment.
- Visits for fitting, counseling, adjustments and repairs for the covered hearing aid.

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## What Is Not Covered

### Hearing Aid Services

The benefit does not include the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss;
2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). Medically necessary surgically implanted hearing devices may be covered under your plan's benefits for prosthetic devices (see "Prosthetic Devices"); or
3. Charges for a hearing aid which is not determined to be medically necessary.

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

### PLAN RX 5-20

	Walk-In				Mail	
	Network		Costco		Costco	Navitus
Days' Supply*	30	90	30	90	90	30
Generic	\$5	N/A	<b>FREE</b>	<b>FREE</b>	<b>FREE</b>	N/A
Brand	\$20	N/A	\$20	\$50	\$50	N/A
Specialty	N/A	N/A	N/A	N/A	N/A	\$20

  

Out-of-Pocket Maximum	\$1,500 Individual / \$2,500 Family
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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 90-day 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](http://www.navitus.com)

Navi-Gate® for Members allows you to access personalized pharmacy benefit information online at [www.navitus.com](http://www.navitus.com). For information specific to your plan, visit Navi-Gate® for Members. 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.