

SISC III ENROLLMENT FORM (DO NOT use for Kaiser members, use Kaiser Permanente enrollment form for Kaiser members)

(Type or print clearly in black ink)

SECTION I: SELECTED COVERAGE – REQUIRED (DISTRICT USE ONLY)

ENROLLMENT REASON: NEW HIRE OPEN ENROLLMENT EMPLOYEE STATUS CHANGE LOSS OF COVERAGE COBRA

QUALIFYING DATE: _____ EFFECTIVE DATE: _____ HIRE DATE: _____ DISTRICT APPROVED INITIALS: _____

DISTRICT NAME (DO NOT ABBREVIATE)		EMPLOYEE GROUP (BARGAINING UNIT) <input type="checkbox"/> Certificated <input type="checkbox"/> Classified <input type="checkbox"/> Management	EMPLOYEE TYPE <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Variable/Temporary/Seasonal	
MEDICAL GROUP NO.	DELTA DENTAL GROUP NO.	VISION GROUP NO.	LIFE GROUP NO.	

SECTION II: EMPLOYEE / APPLICANT INFORMATION – REQUIRED

<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> LIFE	SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)	DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	STREET ADDRESS		CITY	STATE	ZIP
	TELEPHONE NO.	E-MAIL ADDRESS	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO
	MEDICARE COVERAGE If you are retired and entitled to Medicare and not enrolled, you may be subject to a premium surcharge.				
ARE YOU RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO			DO ANY OF YOUR DEPENDENTS HAVE MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES, DO YOU HAVE MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO (Copy of Medicare card required)			(Copy of Medicare card required)		
TOTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO					

SECTION III: DEPENDENT INFORMATION Proof of eligibility required (i.e. birth/marriage/domestic partner certificate)

<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER	LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.			
	GENDER <input type="checkbox"/> M <input type="checkbox"/> F						
<input type="checkbox"/> VISION	ELIGIBLE FOR OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	ENROLLED IN OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF BIRTH	TOTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.			
	ELIGIBLE FOR OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	ENROLLED IN OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF BIRTH	TOTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.			
	ELIGIBLE FOR OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	ENROLLED IN OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF BIRTH	TOTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.			
	ELIGIBLE FOR OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	ENROLLED IN OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF BIRTH	TOTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO

- I understand it is my responsibility to notify my district once a dependent is no longer eligible due to divorce or over age children. If I fail to report loss of eligibility I may be financially liable to SISC if claims were paid on behalf of non-eligible individuals.
- DEDUCTION AUTHORIZATION:** If applicable, I authorize my school district to deduct from my wages the required contribution.
- NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
- HIV Testing Prohibited:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
- EFFECTIVE DATE:** The effective date of coverage is subject to SISC III approval.
- Any complaints regarding the exemption due to the Knox-Keene Health Care Service Plan Act of 1975 may be directed to the Department of Managed Health Care of the State of California.

SECTION IV: SIGNATURE OF UNDERSTANDING – APPLICANT MUST SIGN

I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, SISC, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

ARBITRATION AGREEMENT: I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND SISC III (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. SISC III AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)

Applicant Signature Required _____ Date _____

Your summary of benefits



Anthem® Blue Cross

Your Plan: SISC (Self Insured Schools of California): 100-B \$10 Anthem Classic PPO

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$100 person / \$300 family	
Out-of-Pocket Limit	\$1,000 person / \$3,000 family	No limit person / No limit family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles are combined and accumulate toward each other; however, in-network and out-of-network out-of-pocket maximum amounts accumulate separately and do not accumulate toward each other.</p>		
Preventive Care / Screening / Immunization	No charge	Not covered
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Not covered
<u>Virtual Care (Telemedicine / Telehealth Visits)</u> Virtual Visits - Online visits with Doctors who also provide services in person Primary Care (PCP) <i>The copay is waived for the first three office visits to a primary care provider per benefit period (See footnote 1)</i> Mental Health and Substance Use Disorder care	\$0 copay per visit for visits 1-3, then \$10 copay per visit for visits 4+. (See footnote 1) \$10 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount. (See footnote 2) All billed amounts exceeding the maximum allowed amount. (See footnote 2)

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: Visit us at www.anthem.com/ca/sisc

CA/LG/SISC (Self Insured Schools of California): 100-B \$10 Anthem Classic PPO/04FV/10-01-2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	\$10 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com ; our mobile app, website or Anthem-enabled device Primary Care (PCP) and Mental Health and Substance Use Disorder Specialist Care	No charge \$10 copay per visit deductible does not apply	
<u>Visits in an Office</u> Primary Care (PCP) <i>The copay is waived for the first three office visits to a primary care provider per benefit period (See footnote 1)</i> Specialist Care	\$0 copay per visit for visits 1-3, then \$10 copay per visit for visits 4+. (See footnote 1)	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
<u>Other Practitioner Visits</u> Retail Health Clinic Manipulation Therapy <i>Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit).</i> Acupuncture <i>Coverage is limited to 12 visits per benefit period.</i>	\$10 copay per visit deductible does not apply 0% coinsurance after deductible is met 0% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2) Not covered 50% of maximum allowed amount (See footnote 2)

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy</p> <p>Dialysis/Hemodialysis <i>Coverage for a Non-Network Provider is limited to \$350 maximum per visit. (See footnote 3)</i></p> <p>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>Not covered</p> <p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p> <p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)</p> <p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p> <p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p>X-Ray</p> <p>Office</p> <p>Freestanding Radiology Center</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</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
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office <i>Coverage for a Non-Network Provider is limited to \$800 maximum per test. (See footnote 3)</i></p> <p>Freestanding Radiology Center <i>Coverage for a Non-Network Provider is limited to \$800 maximum per test. (See footnote 3)</i></p> <p>Outpatient Hospital <i>Coverage for a Non-Network Provider is limited to \$800 maximum per test. (See footnote 3)</i></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)</p> <p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)</p> <p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</p> <p>Emergency Room Facility Services <i>Copay waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p>	<p>\$10 copay per visit deductible does not apply</p> <p>\$100 copay per visit and then 0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>\$100 copay per trip and then 0% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Outpatient Mental Health and Substance Use Disorder</u></p> <p>Doctor Office Visit</p> <p>Facility Visit</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$10 copay per visit deductible does not apply</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p> <p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p> <p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital <i>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.</i></p> <ul style="list-style-type: none"> o Arthroscopy limited to \$4,500 per procedure o Cataract surgery limited to \$2,000 per procedure o Colonoscopy limited to \$1,500 per procedure o Upper GI Endoscopy limited to \$1,000 per procedure o Upper GI Endoscopy with biopsy limited to \$1,250 per procedure <p>Freestanding Surgical Center <i>Coverage for a Non-Network Provider is limited to \$350 maximum per day. (See footnote 3)</i></p> <p>Doctor and Other Services</p> <p>Hospital</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p> <p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)</p> <p>All billed amounts exceeding the maximum allowed amount.</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
		(See footnote 2)
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u> <i>Coverage is limited to \$600 benefit maximum per day for non-emergency admission at a Non-Network provider. (See footnote 3)</i></p> <p>Facility Fees</p> <p>Hip/Knee/Spine Surgeries <i>For inpatient services, this benefit is covered only when performed at a designated Blue Distinction Plus Center for Specialty Care. Subject to utilization review.</i></p> <p>Doctor and other services</p>	<p>0% coinsurance after deductible is met</p> <p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p>	<p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)</p> <p>Not Covered</p> <p>All billed amounts exceeding the maximum allowed amount. (See footnote 2)</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Coverage for a Non-Network Provider is limited to \$150 maximum per day. (See footnote 3)</i></p>	<p>0% coinsurance after deductible is met</p>	<p>All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)</p>
<p>Rehabilitation services</p> <p>Office <i>Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit).</i></p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Office</p>	<p>0% coinsurance after deductible is met</p>	<p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i> <i>Coverage for a Non-Network Provider is limited to \$600 maximum per day.</i> <i>(See footnote 3)</i>	0% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Inpatient Hospice	No charge	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Durable Medical Equipment	0% coinsurance after deductible is met	Not covered
Prosthetic Devices	0% coinsurance after deductible is met	Not covered
Hearing Aids <i>Benefit is limited to \$700 every 24 months. (See footnote 3)</i>	0% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)

Footnote 1: The office visit copay is waived for the first three office visits to a primary care provider 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 providers are defined as General and Family Practitioners, Internists, Gynecologists, Obstetrics/Gynecology, Pediatricians and Nurse Practitioners. The office visit copay will apply to all other provider specialties.

Footnote 2: When using Non-Network PPO Providers, members are responsible for any difference between the maximum allowed amount and actual charges, as well as any deductible & percentage copay.

Footnote 3: The plan may pay for the following services and supplies up to the maximum number of days or visits and/or dollar maximum shown. When using non-network providers, the plan will pay the lesser of the benefit maximum or the maximum allowed amount. If the maximum allowed amount is less than the listed benefit maximum, the plan will not exceed the maximum allowed amount. Likewise, if the listed benefit maximum is less than the maximum allowed amount, the plan will not exceed the listed benefit maximum.

Notes:

- If you have an office visit with your Primary Care Physician or Specialist 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 Benefit Booklet for details.
- 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 that may apply to the coverage. For more details, important limitations and exclusions, please review the Benefit Booklet. If there is a difference between this summary and the Benefit Booklet, the Benefit Booklet will prevail.

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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 أيضا الحصول على هذا الخطاب مكتوبا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورا 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 យើងអាចជួយអ្នកក្នុងការអានសំខុំអានបាន។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីដោយមិនមានការបង្ខំអ្នកផងដែរ។ បើអ្វីៗទទួលបានជោគជ័យស្របច្បាប់ សូមហៅទូរស័ព្ទតាមលេខ 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 ਤੁਸ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹ , ਤਾਂ ਅਸ ਇਸ ਨੂੰ ਪੜ੍ਹ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ ਸਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਿਖਆ ਹੋਇਆ ਵਬੀ ਪਰਾਪ ਼ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੋਰਨ 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 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>.

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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	FREE	FREE	FREE	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					

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.