blue of california

Self-Insured Schools of California
Effective October 1, 2023
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.

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	$0		50%	
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	$0		50%	
Up to 12 visits per Member, per Calendar Year.				
Chiropractic services	$0		Not covered	
Up to 20 visits per Member, per Calendar Year.				
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%	
Medical nutrition therapy, not related to diabetes	$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% Subject to a Benefit maximum of $350/day	
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% Subject to a Benefit maximum of $350/day	
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	
Prosthetic equipment and devices	$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
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		50%	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	$0		50%	
Hemophilia home infusion services *Includes blood factor products.*	$0		50%	
Skilled Nursing Facility (SNF) services *Up to 150 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		50%	
Routine home care	$0		50%	
24-hour continuous home care	$0		50%	
Short-term inpatient care for pain and symptom management	$0		50%	
Inpatient respite care	$0		50%	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	$0		50%	
• Self-management training	$0		50%	
• Medical nutrition therapy	$0		50%	
Dialysis services	$0		50% Subject to a Benefit maximum of $350/day	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
PKU product formulas and special food products	$0		Not covered	
Allergy serum billed separately from an office visit	$0		50%	
Hearing aid services				
• Hearing aids and equipment	$0		$0	
Up to $700 combined maximum per Member, per 24 month period.				
• 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% Subject to a Benefit maximum of $350/day	
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 and office-based opioid treatment
- 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 Calendar Year 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.
- 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.

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

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount 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.

Notes

- 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):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered, charges above a the Allowable Amount, and charges for services above any 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 payment in addition to an allergy serum payment 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.

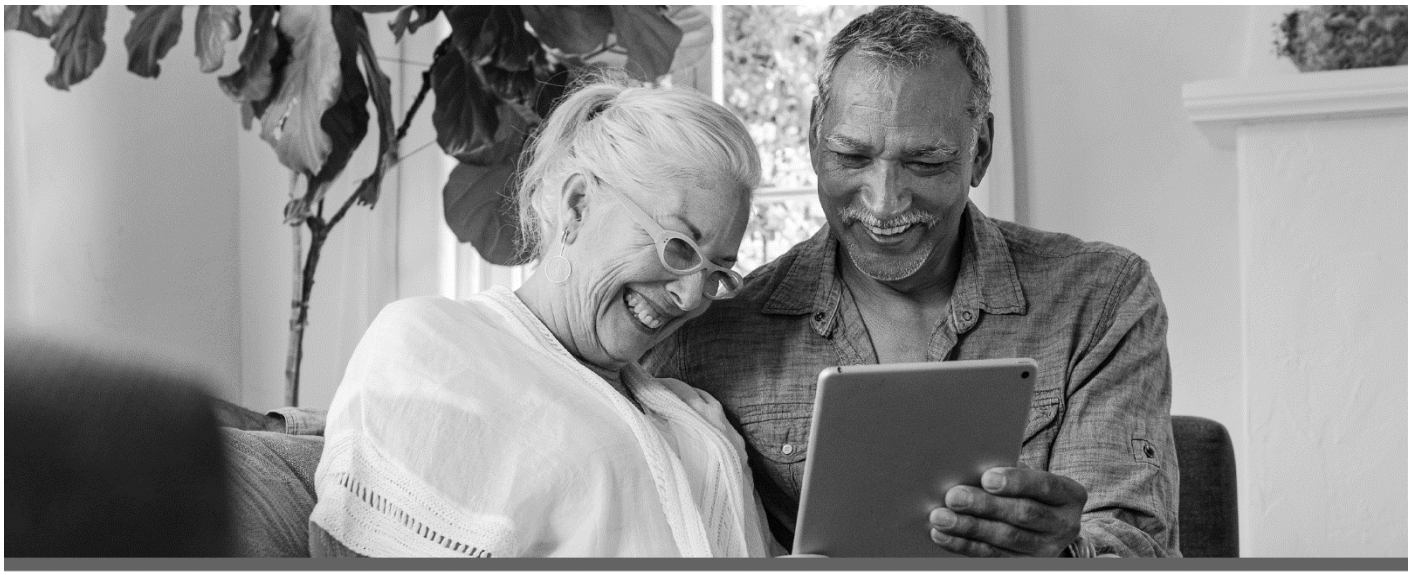
Authorized Referrals for Services by Non-Preferred/Non-Participating//MHSA Non-Participating Providers –

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.
PB042023



NAVITUS MEDICARERX (PDP)
2023 SUMMARY OF BENEFITS
Self-Insured Schools of California (SISC) – Plan 0X35

This Summary of Benefits explains some of the features of the Self-Insured Schools of California Navitus MedicareRx Prescription Drug Plan (PDP) for your enrollment in the Medicare plan, however it does not list every benefit, limitations, or exclusion. To get a complete list of your benefits, please refer to your 2023 Evidence of Coverage, which is available on the website at Medicarerx.navitus.com. To log into the member portal click on Members, then Login. Or contact Navitus MedicareRx Customer Care toll-free at 1-866-270-3877 (TTY/TDD users should call 711). Calls to these numbers are free. Members can call Customer Care 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day.

Included in this mailing is information on how to access your Evidence of Coverage, Formulary and Pharmacy Directory, on the website at Medicarerx.navitus.com. To log into the member portal click on Members, then Login.

Important: Existing members will not receive a new ID card each year. The ID card will only be mailed for new enrollees. If you need a replacement card, please contact Customer Care with your request. The number is listed on the back cover.

This plan, Navitus MedicareRx (PDP), offered by Dean Health Insurance, Inc., is a Federally Qualified Medicare Contracting Prescription Drug Plan.

NAVITUS
MedicareRx (PDP)

Important Contact Information

Navitus MedicareRx Customer Care – 1-866-270-3877 (TTY/TDD users should call 711). Calls to these numbers are free, and available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Customer Care has free language interpreter services available for non-English speakers.

Pharmacies can also reach Navitus Customer Care 24 hours a day, 7 days a week.

Navitus MedicareRx Website and Member Portal - Medicarerx.navitus.com Use this portal to access the most up to date formulary, pharmacy directory, and to review the current year's benefit booklets. You will need to register with this website to access your specific and updated information when visiting the Member Portal. To log into the member portal click on Members, then Login.

Navitus Prescriber Portal – https//prescribers.navitus.com
Your primary care physician or prescribing physician can use this portal to access your Formulary and to begin to initiate a Prior Authorization on your behalf.

Navitus Network Pharmacy Portal - https://pharmacies.navitus.com
Your pharmacy can use this portal to access your Formulary.

Self-Insured Schools of California (SISC) - For information about plan premiums, eligibility, or enrollment options please contact SISC at 1-661-636-4410.

Centers for Medicare & Medicaid Services (CMS) - CMS is the Federal agency that administers and regulates Medicare. For information on the Medicare benefit only (not related to your supplemental/retiree plan) we recommend reviewing CMS's *Medicare & You* booklet. This booklet is mailed out in September to all Medicare households by CMS. You can also sign up to get this handbook electronically at MyMedicare.gov, or order a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free and you can call 24 hours a day, 7 days a week.

Navitus MedicareRx (PDP) Summary of Benefits 2023

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 preferred/non-preferred; mail order; long term care; home infusion; one-month or extended-day supplies; and what stage of the Medicare Part D benefit you're in. For more information on the additional pharmacy specific cost-sharing, the stage of the benefit, or a complete description of benefits, please call us or access your Evidence of Coverage online at Medicarerx.navitus.com, click on Members, then Login. New members will need their ID card prior to registering on the portal.

Yearly Deductible Stage:

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

Initial Coverage Stage:

During this stage, the plan pays its share of the cost of your drug and you pay your share of the cost. The table below shows your cost share in each of the plan's drug tiers and shows your payment responsibility until the Initial Coverage Limit reaches $4,660, when you move on to the Coverage Gap 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 high-cost products; includes all specialty products	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$90 copayment

Tier $0 - Certain preventative medications are available for $0 (specific guidelines apply)

Coverage Gap Stage:

You will continue to pay the same cost sharing amounts for your drugs as you paid in the Initial Coverage Stage until your yearly out-of-pocket Part D drug costs reach $7,400, when you qualify for the Catastrophic Coverage Stage. Your drug copay or coinsurance may be less, based upon the cost of the drug.

Catastrophic Coverage Stage:

After your yearly out-of-pocket drug costs reach $7,400 for Part D drugs, *you pay the greater* of either:

5% coinsurance **-or-** a $4.15 copay for generic (including brand drugs treated as generic) / $10.35 copay for all other drugs.

-OR- Your formulary cost sharing 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.
- Your plan will allow up to a 10-day supply of medication at an out-of-network pharmacy.
- Drugs marked as **NDS** (**N**on-extended **D**ay **S**upply) on the formulary are not available for an extended supply (greater than a 1-month supply) at retail, mail order or specialty pharmacy.
- If you reside in a long-term care facility, you receive a 31-day supply for a 1-month copay/coinsurance.
- **Important Message About What You Pay for Vaccines** – Our plan covers most Part D vaccines at no cost to you. Call Customer Care for more information.
- **Important Message About What You Pay for Insulin** – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier its's on.

For a complete description of benefits, please call Customer Care (numbers on back cover) or access the Evidence of Coverage on the website at Medicarerx.navitus.com, click on Members, then Login.

Additional Coverage Information

More detailed plan information is provided in your Evidence of Coverage. You can also access these documents online at Medicarerx.navitus.com, (then log into the member portal by clicking on Members, then Login). You can ask for information regarding the Evidence of Coverage, Formulary or Pharmacy Directory by calling Navitus MedicareRx Customer Care, the number is listed on the back cover.

Additional Help for Medicare called "Extra Help"

Programs are available to help people with low or limited income and resources pay for prescriptions. If you qualify, your Medicare prescription plan costs for your drug costs at the pharmacy and the amount of your premium (there are four different premium levels and does not include any Part B premiums) will be less. Once you are enrolled in Navitus MedicareRx, Medicare will tell us how much assistance you will be receiving, and we will send you information on the amount you will pay for your prescriptions.

If you think you may qualify for Medicare's "Extra Help" program, call Social Security 1-800-772-1213, between 8 am and 7 pm, Monday through Friday to apply for the program. TTY/TDD users should call 1-800-325-0778. You may also be able to apply at your State Medical Assistance or Medicaid Office. If you qualify for extra help, we have included a letter in your packet, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider. For more information on how to get help with drug plan costs, see Chapter 2, section 7 of your Evidence of Coverage.

Coverage Determination

If your physician prescribes a drug that is not on our drug list, is not a preferred drug, or is subject to additional utilization rules (see below), you may ask us to make a coverage exception. In addition, if Navitus MedicareRx ever denies coverage for your prescriptions, we will explain our decision to you. You always have the right to appeal our decision or ask us to review a claim that was denied.

For certain drugs, you or your prescriber need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**". Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

A requirement to try a different drug first is called "**step therapy**". Trying a different drug first, encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan may then cover Drug B. A requirement to try a different drug first is called "**step therapy**".

For certain drugs, you may be limited in the amount of the drug you can have, by limiting the quantity of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. A requirement that limits the quantity of a drug you can get filled, is called "**quantity limits**".

Creditable Drug Coverage

Creditable drug coverage is as good as Medicare's standard prescription drug coverage. Creditable coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. A late enrollment penalty is imposed on individuals who do not maintain creditable coverage for any period of 63 days or longer after being first eligible for the Medicare Part D benefit.

Income Related Monthly Adjustment Amount (IRMAA)

If your modified adjusted gross income (MAGI) as reported on your IRS tax return from 2 years ago was above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium. For more information, see Chapter 1, Section 4 of the Evidence of Coverage.

Network Pharmacies

The first step to filling your prescription is deciding on a participating network pharmacy. We have network pharmacies across the country where you can obtain your prescriptions as a member of our plan. There is a pharmacy search tool and a complete list of network pharmacies on the Member Portal. Go to Medicarerx.navitus.com (click on Members, then Login). To access the pharmacy search tool, click on *Pharmacy Search* on the top navigation bar. You are able ask about network pharmacies or request a pharmacy directory to be mailed to you by calling Navitus MedicareRx Customer Care, the number is listed on the back cover.

In the event of an emergency where you are not able to utilize a network pharmacy, an out-of-network pharmacy may be able to fill your prescription. Your plan will allow up to a 10-day supply of medication at an out-of-network pharmacy.

Recommended Mail Order Pharmacy

Our mail order service offers an easy way for you to get up to a 90-day supply of your long-term or maintenance medications. You can use any contracted network pharmacy you like, currently the recommended mail order pharmacy is Costco Mail Order Pharmacy. You can reach Costco Mail Order Pharmacy by calling 1-800-607-6861, or by going to their website, pharmacy.costco.com.

Using the recommended mail order pharmacy allows you to have your medications delivered to your home and in some cases at a lower rate than if you purchased at a retail pharmacy.

Note: Costco Mail Order Pharmacy use does not require a Costco Warehouse membership.

Recommended Specialty Pharmacy

You can use any contracted specialty pharmacy you like, however Navitus recommends Lumicera Specialty Pharmacy to provide the best home-delivery service and rates on specialty drugs. You can contact Lumicera's Customer Care at 1-855-847-3553 (TTY/TDD 711). There is a pharmacy search tool and a complete list of network pharmacies on the Member Portal. Go to Medicarerx.navitus.com and click on Members, then Login, to access these pharmacy tools.

Refilling Prescriptions at a New Pharmacy

If you are looking to switch to a new pharmacy, automatic prescription refill transfers do not happen. Please give your Navitus ID card to your *new* pharmacy and let them know at which pharmacy the prescription refills are located, and the medication names/strengths. Your *new* pharmacy can work with the previous pharmacy to see if these refills can be transferred. Some prescriptions may not be allowed to transfer, and in that case, your prescriber will need to write a new prescription.

Supplemental Coverage

Supplemental Coverage, also known as Wrap coverage, is provided as part of your prescription benefit. This supplemental coverage may pay for prescription drugs even when Medicare does not cover them. However, you will still be responsible for paying your copayments or coinsurance.

General Information

What will I pay for Navitus MedicareRx premiums?

Your coverage is provided through a contract with your current employer or former employer. Please contact SISC for information about your 2023 plan premium.

Where is Navitus MedicareRx available?

The service area for Navitus MedicareRx includes all 50 states and Puerto Rico. The service area excludes most U.S. Territories, such as the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. You must live in the service area to join Navitus MedicareRx. If you reside outside the service area you are not eligible to be enrolled in Navitus MedicareRx.

If you plan to move out of the service area, please contact SISC. You will need to opt out of the Navitus MedicareRx plan and enroll in another Medicare Part D plan available in your new service area.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5, of your Evidence of Coverage.

Who is eligible to join?

You, your spouse, and dependents are eligible to join if you qualify for your plan's Medicare retiree coverage through Navitus MedicareRx; you are enrolled in Medicare Parts A and B; and you live in the service area. Your premium for Medicare Parts A and B must be paid in order to keep your Medicare Parts A and B coverage and to remain a member of this plan.

How do I know which medications the Navitus MedicareRx Formulary covers?

The Navitus MedicareRx Formulary is a list of drugs selected to meet patient needs. Navitus MedicareRx may periodically make changes to the Formulary. In the event of CMS-approved non-maintenance changes to the Formulary throughout the plan year, Navitus MedicareRx will notify you. Additionally, you may log in to the website at Medicarerx.navitus.com. Click on Members, then Login, to get to the member portal.

Does my plan cover Medicare Part B or Part D drugs?

Navitus MedicareRx does not cover drugs that are covered under Medicare Part B as prescribed and dispensed, although the supplemental coverage benefit provided by SISC will pay secondary to Medicare Part B on select items such as diabetic testing supplies (review the Formulary to confirm coverage). Generally, we only cover drugs, vaccines, biologics, and medical supplies that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on the Formulary. The drugs on the Formulary are selected by Navitus MedicareRx with the help of a team of doctors and pharmacists. The list must meet specific requirements set by Medicare. Medicare has approved the Navitus MedicareRx Formulary. The supplemental portion of your plan covers some additional drugs that are not typically part of the standard Medicare Part D formulary.

What is a Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a service Navitus MedicareRx offers. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. There is no cost to you to participate in the MTM Program. If you have questions concerning our MTM Program please contact our Navitus MedicareRx Customer Care number listed on the back cover. For additional information regarding Medication Therapy Management, please refer to Chapter 3, Section 10, of your Evidence of Coverage.

What are my protections in the plan?

All Medicare prescription plans agree to stay in the program for a full year at a time. Each year, your employer group decides whether to continue for another year. If a plan decides not to continue, they must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare prescription coverage in your area.

Please call Navitus MedicareRx (PDP) for more information about this plan.

Navitus MedicareRx Customer Care: Toll-free 1-866-270-3877 or TTY/TDD users should call 711, 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day.

Pharmacies can call Navitus MedicareRx 24 hours a day, 7 days a week.

Navitus MedicareRx (PDP) Website and Member Portal:

- **Current members:** You may access our website and Member Portal by going to Medicarerx.navitus.com, click on Members, then Login.
- **New members:** Once you receive your ID card, first time users can register at Medicarerx.navitus.com for access to the Member Portal.

For more information about **Medicare**, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free and you can call 24 hours a day, 7 days a week. Or visit www.medicare.gov.