Your summary of benefits

Anthem.

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: SISC (Self Insured Schools of California): 80-K $30 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	$1,000 person / $2,000 family	
Overall Out-of-Pocket Limit	$3,000 person / $6,000 family	No limit person / No limit family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out-of-pocket limit(s). The In-Network and Non-Network deductibles are combined and accumulate toward each other; however, In-Network and Non-Network out-of-pocket limit amounts accumulate separately and do not accumulate toward each other. *For services received from an out-of-network provider, the member may be held responsible for any costs beyond the permitted amount and the overall charges.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at No charge.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse disorder care via www.livehealthonline.com are covered at No charge; and $30 copay per visit deductible does not apply for covered Specialist Care.*		
Primary Care (PCP) *virtual and office* *The copay is waived for the first three office visits to a primary care provider per benefit period. (See footnote 1)*	$0 copay per visit for visits 1-3, then $30 copay per visit for visits 4+. *(See footnote 1)*	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.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Mental Health and Substance Abuse Disorder Care *virtual and office*	$30 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Specialist Care *virtual and office*	$30 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Other Practitioner Visits		
Maternity Care (Prenatal and Postnatal Global Care)	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$30 copay per visit deductible does not apply	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Manipulation Therapy *Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit).*	20% coinsurance after deductible is met	Not covered
Acupuncture *Coverage is limited to 12 visits per benefit period.*	20% coinsurance after deductible is met	50% of maximum allowed amount (See footnote 2)
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	Not covered
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Surgery	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Preventive care / screenings / immunizations	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services **Lab**		
Office	20% coinsurance after deductible is met	Not covered
Freestanding Lab	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
X-Ray		
Office	20% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office *Coverage for a Non-Network Provider is limited to $800 maximum per test. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Freestanding Radiology Center *Coverage for a Non-Network Provider is limited to $800 maximum per test. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Outpatient Hospital *Coverage for a Non-Network Provider is limited to $800 maximum per test. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$30 copay per visit deductible does not apply	All billed amounts exceeding the

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
		maximum allowed amount. (See footnote 2)
Emergency Room Facility Services *Copay waived if admitted.*	$100 copay per visit and 20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	$100 copay per trip and 20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Disorder Care at a Facility		
Facility Fees	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Doctor Services	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Outpatient Surgery		
Facility Fees		
Hospital *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.* 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*	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Ambulatory Surgical Center *Coverage for a Non-Network Provider is limited to $350 maximum per day. (See footnote 3)*	20% coinsurance after deductible is met	$50 copay after deductible. All billed amounts exceeding the lesser of the benefit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
		maximum or maximum allowed amount. (See footnote 2 and 3)
Doctor and Other Services		
Hospital	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Hospital (Including Maternity, Mental Health and Substance Abuse Disorder) *Coverage is limited to $600 benefit maximum per day for non-emergency admission at a Non-Network provider. (See footnote 3)*		
Facility Fees	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Hip/Knee/Spine Surgeries *For inpatient services, this benefit is covered only when performed at a designated Blue Distinction Plus Center for Specialty Care. Subject to utilization review.*	20% coinsurance after medical deductible is met	Not Covered
Physician and other services	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Home Health Care *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)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Rehabilitation Services		
Office *Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit).*	20% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis *office and outpatient hospital* *Coverage for a Non-Network Provider is limited to $350 maximum per visit. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount. (See footnote 2 and 3)
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after deductible is met	All billed amounts exceeding the maximum allowed amount. (See footnote 2)
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.* *Coverage for a Non-Network Provider is limited to $600 maximum per day. (See footnote 3)*	20% 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	20% coinsurance after deductible is met	Not covered
Prosthetic Devices	20% coinsurance after deductible is met	Not covered
Hearing Aids *Coverage is limited to $700 maximum every 24 months. (See footnote 3)*	20% coinsurance after deductible is met	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
		(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, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Surgery at Ambulatory Surgical Centers and Hemodialysis are limited to $350 per admission for Non-Network Providers.
- Advanced Diagnostic Imaging is limited to $800 per service for Non-Network Providers.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- The representations of benefits in this document are subject to California Department of Insurance (DOI) approval and are subject to change.

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

Intentionally Left Blank

Get help in your language

Notice of Language Assistance

Curious to know what all this says? We would be too. Here's the English version:
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (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
Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

Arabic
يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721.
للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357. (TTY/TDD: 711)

Armenian
Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

Chinese
免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者1-888-254-2721聯絡我們。如需更多協助，請撥打1-800-927-4357 聯絡CA Dept. of Insurance。(TTY/TDD: 711)

Farsi
خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخواهید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721
با ما تماس بگیرید. برای دریافت کمکهای بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD:711)

Hindi

Anthem Blue Cross Life and Health Insurance Company is an independent licensee 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.

बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग कोकॉल करें। (TTY/TDD: 711)

Hmong

Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

Japanese

無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局（1-800-927-4357）にお電話ください。(TTY/TDD: 711)

Khmer

សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា។ អ្នកអាចឲ្យគេអានឯកសារផ្សេងៗជូនអ្នក និងផ្ញើឯកសារជូនអ្នកជាភាសារបស់អ្នក។ ដើម្បីទទួលជំនួយ សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានតាមយន្តនៅលើប័ណ្ណ ID របស់អ្នក ឬតាមលេខ 1-888-254-2721។ ដើម្បីទទួលជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។(TTY/TDD: 711)

Korean

무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

Punjabi

ਿਬਨਾਂ ਿਕਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪਰ੍ਾਪ ਤ੍ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਿਵੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉ ਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਿਜ਼ਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਿਡਪਾਰਟਮ ਟ ਔਫ ਇਨਸ਼ੋਰ ਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

Tagalog

Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

Thai

ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการล่ามได้
ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357 (TTY/TDD: 711)

Anthem Blue Cross Life and Health Insurance Company is an independent licensee 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.

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (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.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee 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.

SISC
Self-Insured Schools of California
Schools Helping Schools

NAVITUS HEALTH SOLUTIONS

Pharmacy Benefit Schedule

PLAN RX 9-35

	WALK-IN				MAIL	
	Network		Costco		Costco	Navitus
Days' Supply*	30	90	30	90	90	30
Generic	$9	N/A	FREE	FREE	FREE	N/A
Brand	$35	N/A	$35	$90	$90	N/A
Specialty	N/A	N/A	N/A	N/A	N/A	$35

Out-of-Pocket Maximum	$2,500 Individual / $3,500 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 a 30-day and/or up to a 90-day 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; however, Walgreens is **NOT** a participating pharmacy in this network.

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.