# 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

| Visits with Virtual Care-Only Providers | Cost through our mobile app and website |
|---|---|
| **Primary Care, and medical services for urgent/acute care** | No charge |
| **Mental Health & Substance Use Disorder Services** | No charge |
| **Specialist care** | $30 copay per visit deductible does not apply |

| 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 | $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.<br>All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit.<br>In-Network and Non-Network deductibles is combined and accumulate toward each other.<br>*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).* | | |
| **Primary Care (PCP)** *virtual and office*<br>*The copay is waived for the first three office visits to a primary care provider per benefit period.* | $0 copay per visit for visits 1-3, then $30 copay per visit for visits 4+. | All billed amounts exceeding the maximum allowed amount* |
| **Mental Health and Substance Use Disorder Services** *virtual and office* | $30 copay per visit deductible does not apply | All billed amounts exceeding the maximum allowed amount* |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Specialist Care** *virtual and office* | $30 copay per visit deductible does not apply | All billed amounts exceeding the maximum allowed amount* |
| **Other Practitioner Visits** | | |
| **Routine Maternity Care** (Prenatal and Postnatal Global Care) | 20% coinsurance after deductible is met | All billed amounts exceeding the maximum allowed amount* |
| **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* |
| **Manipulation Therapy** *Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit of physical, occupational or chiropractic care.* | 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* |
| **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* |
| **Surgery** | 20% coinsurance after deductible is met | All billed amounts exceeding the maximum allowed amount* |
| **Preventive care / screenings / immunizations** | No charge | Not covered |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge | Not covered |
| **Diagnostic Services** | | |
| **Lab** | | |
| Office | 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 |
|---|---|---|
| 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<br>*Coverage for a Non-Network Provider is limited to $800 maximum per test* | 20% coinsurance after deductible is met | All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| Freestanding Radiology Center<br>*Coverage for a Non-Network Provider is limited to $800 maximum per test* | 20% coinsurance after deductible is met | All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| Outpatient Hospital<br>*Coverage for a Non-Network Provider is limited to $800 maximum per test* | 20% coinsurance after deductible is met | All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| **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 maximum allowed amount* |
| **Emergency Room Facility Services**<br>*Your copay will be 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 |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Ambulance**<br>*Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.* | $100 copay per trip and 20% coinsurance after deductible is met | Covered as In-Network |
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| Facility Fees | 20% coinsurance after deductible is met | All billed amounts exceeding the maximum allowed amount* |
| Doctor Services | 20% coinsurance after deductible is met | All billed amounts exceeding the maximum allowed amount* |
| **Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital<br>*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.*<br>o *Arthroscopy limited to $4,500 per procedure*<br>o *Cataract surgery limited to $2,000 per procedure*<br>o *Colonoscopy limited to $1,500 per procedure*<br>o *Upper GI Endoscopy limited to $1,000 per procedure*<br>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* |
| Ambulatory Surgical Center<br>*Coverage for a Non-Network Provider is limited to $350 maximum per day.* | 20% coinsurance after deductible is met | $50 copay per visit after deductible is met* and all billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| **Physician and other services** *including surgeon fees* | | |
| Hospital | 20% coinsurance after deductible is met | All billed amounts exceeding the maximum allowed amount* |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)**<br>*Anthem's maximum payment is up to $600 per day for non-emergency Inpatient admissions to Non-Network providers.* | | |
| **Facility Fees** | 20% coinsurance after deductible is met | All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| **Hip/Knee/Spine Surgeries**<br>*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 deductible is met | Not covered |
| **Physician and other services** *including surgeon fees* | 20% coinsurance after deductible is met | All billed amounts exceeding the maximum allowed amount* |
| **Home Health Care**<br>*Coverage is limited to 100 visits per benefit period.*<br>*Coverage for a Non-Network Provider is limited to $150 maximum per day.* | 20% coinsurance after deductible is met | All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.* | | |
| Office<br>*Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit of physical, occupational or chiropractic care.* | 20% coinsurance after deductible is met | Not covered |
| 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* |
| **Cardiac rehabilitation** *office and outpatient hospital* | 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 |
|---|---|---|
| **Dialysis/Hemodialysis** *office and outpatient hospital*<br>*Coverage for a Non-Network Provider is limited to $350 maximum per visit.* | 20% coinsurance after deductible is met | All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | 20% coinsurance after deductible is met | All billed amounts exceeding the maximum allowed amount* |
| **Skilled Nursing Care (facility)**<br>*Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*<br>*Coverage for a Non-Network Provider is limited to $600 maximum per day.* | 20% coinsurance after deductible is met | All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |
| **Inpatient Hospice** | No charge | All billed amounts exceeding the maximum allowed amount* |
| **Durable Medical Equipment** | 20% coinsurance after deductible is met | Not covered |
| **Prosthetic Devices** | 20% coinsurance after deductible is met | Not covered |
| **Hearing Aids**<br>*Coverage is limited to $700 maximum every 24 months.* | 20% coinsurance after deductible is met | All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount* |

**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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- 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 office visit copay is waived for the first three office visits to a Primary Care Physician 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 Physician is defined as General and Family Practitioner, Internist, Gynecologist, Obstetric/Gynecology, Pediatrician and Nurse Practitioner. The office visit copay will apply to all other provider specialties.

*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.*

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Questions: (800) 888-8288 or visit us at www.anthem.com/ca

Anthem

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# 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
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)

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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។ អ្នកអាចទទួលអ្នកបកប្រែម្នាក់។ អ្នកអាចឲ្យគេអានឯកសារផ្សេងៗជូនអ្នក និងផ្ញើឯកសារជូនអ្នកជាភាសារបស់អ្នក។ ដើម្បីទទួលជំនួយ សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើប័ណ្ណ ID របស់អ្នក ឬក៏លេខ 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 ੍ਾਪ 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)

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)

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### 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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SISC
Self-Insured Schools of California
*Schools Helping Schools*

NAVITUS HEALTH SOLUTIONS

# Pharmacy Benefit Schedule

## PLAN RX 200DED/10-35

| | WALK-IN | | | | MAIL | |
|---|---|---|---|---|---|---|
| | Network | | Costco | | Costco | Navitus |
| Days' Supply* | 30 | 90 | 30 | 90 | 90 | 30 |
| Generic | $10 | 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 |
| Brand/Specialty Deductible** | $200 Individual / $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. Monies paid in the 4th quarter (October-December) towards the deductible are carried over to the next calendar year.

*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; however, Walgreens is **NOT** a participating pharmacy in this network.

**Deductible only applies to Brand and Specialty drugs. Copays apply only after the brand deductible is met.

**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.