# Your summary of benefits

Anthem

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: SISC (Self Insured Schools of California): 80-G $30 Anthem Classic PPO

Your Network: Select 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 an Out-of-Network Provider |
|---|---|---|
| **Overall Deductible** | $500 person / $1,000 family | $500 person / $1,000 family |
| **Overall Out-of-Pocket Limit** | $2,000 person / $4,000 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 Out-of-Network deductibles are combined and accumulate toward each other; however, In-Network and Out-of-Network out-of-pocket limit amounts accumulate separately and do not 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.*** | $30 copay per visit for visits 4+. Deductible does not apply | 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 an Out-of-Network Provider |
|---|---|---|
| **Specialist Provider** *virtual and office* | $30 copay per visit deductible does not apply | All billed amounts exceeding the maximum allowed amount* |
| **Other Practitioner Visits** | | |
| **Maternity Doctor services** (prenatal/postpartum care and delivery) | $30 copay per visit deductible does not apply | 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 through American Specialty Health (ASH) is required for physical, occupational or chiropractic services* | 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 an Out-of-Network Provider |
|---|---|---|
| **Freestanding Lab** | 20% coinsurance after deductible is met | Not covered |
| **Outpatient Hospital** | 20% coinsurance after deductible is met | Not covered |
| **Diagnostic Services - 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 |
| **Diagnostic Services - Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| **Office**<br>*Coverage for an Out-of-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 an Out-of-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 an Out-of-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* |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **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 |
| **Ambulance**<br>*Authorized Out-of-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 an Out-of-Network Provider is limited to $350 maximum per day.* | 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 an Out-of-Network Provider |
|---|---|---|
| **Physician and other services** *including surgeon fees* | 20% coinsurance after deductible is met | All billed amounts exceeding the maximum allowed amount* |
| **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 Out-of-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 | All billed amounts exceeding the maximum allowed amount* |
| **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. Coverage for an Out-of-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* |
| **Therapy Services** | | |
| **Rehabilitation and Habilitation services** | | |
| **Office**<br>*Pre-authorization review through American Specialty Health (ASH) is required for physical, occupational or chiropractic services* | 20% coinsurance after deductible is met | Not covered |
| **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 an Out-of-Network Provider |
|---|---|---|
| **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 |
| **Dialysis/Hemodialysis** *office and outpatient hospital*<br>*Coverage for an Out-of-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. Coverage for an Out-of-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* |
| **Additional Services, Equipment and Devices**<br>**Durable Medical Equipment** | 20% coinsurance after deductible is met | Not covered |
| **Prosthetic Devices** | 20% coinsurance after deductible is met | Not covered |
| **Wigs**<br>*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | 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.
- Outpatient Facility tests and treatments are limited to $350 per admission for Out-of-Network Providers. Includes: Surgery at Ambulatory Surgical Centers and Hemodialysis.
- Advanced Diagnostic Imaging is limited to $800 per service for Out-of-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. Members' 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, Obstetrics/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) 825-5541 or visit us at www.anthem.com/ca/sisc

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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: 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 alternative 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 solicitar los servicios de un intérprete. También puede solicitar que le leamos y le enviemos algunos documentos en su idioma. Llame al número que figura en su tarjeta de identificación o al 1-888-254-2721. Si necesita más ayuda, llame al Departamento de Seguros de California al 1-800-927-4357 (TTY/TDD: 711).

**Arabic**

خدمات لغوية مجانية. يمكنك الحصول على مترجم فوري. يمكنك الحصول على مستندات تُقرأ لك وإرسال بعضها إليك بلغتك.
للحصول على المساعدة، اتصل بنا على الرقم المدرج على بطاقة الهوية الخاصة بك أو 1-800-254-2721. لمزيد من المساعدة اتصل بقسم التأمين في CA على الرقم 1-800-927-4357 (TTY/TDD: 711)

**Armenian**

Առանց արժեքի լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Դուք կարող եք ստանալ փաստաթղթեր, որոնք կարդում են ձեզ համար, իսկ որոշները՝ ուղարկվում են ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ID քարտում նշված համարով կամ 1-888-254-2721 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք CA Ապահովագրության բաժանմունք՝ 1-800-927-4357 (TTY/TDD՝ 711)

**Chinese**

免費語言服務。您可獲得口譯員服務。可以把文件唸給您聽，有些文件有您的語言的版本，也可以把這些文件寄給您。欲取得協助，請致電您的 ID 卡所列的電話號碼，或致電 1-888-254-2721 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 (TTY/TDD: 711) 與 CA 保險部聯絡

**Farsi**

خدمات زبان بدون هزینه. شما می‌توانید مترجم شفاهی درخواست کنید. می‌توانید بخواهید اسناد برای شما به زبان شما خوانده شود و برخی اسناد به زبان شما برایتان ارسال شود.
برای راهنمایی، با ما با شماره مندرج در کارت عضویت خود یا شماره 1-888-254-2721 تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه CA به شماره 1-800-927-4357 (TTY/TDD: 711) تماس بگیرید.

**Hindi**

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ अपनी भाषा में पढ़वा सकते हैं और कुछ को अपनी भाषा में खुद तक भिजवा सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिए गए नंबर पर या 1-888-254-2721 पर हमें कॉल करें। अधिक सहायता के लिए सीए बीमा विभाग को 1-800-927-4357 पर कॉल करें (TTY/TDD: 711)

**Hmong**

Tsis Sau Nqi Rau Kev Pab Cuam Txog Lus. Koj tuaj yeem tau txais tus kws txhais lus. Koj tuaj yeem tau txais cov ntaub ntawv kom muab nyeem rau koj mloog thiab kom muab xa rau koj ua yam lus koj hais. Rau kev pab, hu peb tus npawb xov tooj muaj nyob ntawm koj daim npav ID los sis 1-888-254-2721. Rau kev pab ntxiv hu lub CA Tuam Tsev Hauj Lwm ntsig txog Kev Tuav Pov Hwm ntawm 1-800-927-4357 (TTY/TDD: 711)

**Japanese**

無料の言語サービス。通訳を頼むこともできます。文書を使用言語で読み上げたり、送信したりすることもできます。サポートが必要な場合、ID カードに記載されている電話番号または 1-888-254-2721 までお電話ください。さらに詳しい情報については、カリフォルニア州保険局までお問い合わせください。電話番号：1-800-927-4357（TTY/TDD: 711）

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**Khmner**

មិនគិតថ្លៃសេវាភាសាទេ។ អ្នកអាចទទួលបានអ្នកបកប្រែ។ អ្នកអាចទទួលបានឯកសារអានឱ្យអ្នកស្តាប់ និងឯកសារខ្លះផ្ញើឱ្យអ្នកជាភាសារបស់អ្នក។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងតាមលេខដែលមាននៅក្នុងកាត ID របស់អ្នក ឬ 1-888-254-2721។ សម្រាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅផ្នែកធានារ៉ាប់រង CA តាមរយៈលេខ 1-800-927-4357 (TTY/TDD: 711)

**Korean**

무상 언어 서비스. 통역사를 연결시켜 드립니다. 문서를 귀하에게 읽어드릴 수 있고 어떤 서류는 귀하의 언어로 작성하여 댁으로 보내드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 나와 있는 번호 또는 1-888-254-2721 번으로 전화해 주시기 바랍니다. 더 많은 도움이 필요하시면 CA 보험부에 1-800-927-4357 (TTY/TDD: 711)로 전화해 주십시오.

**Punjabi**

ਬਿਨਾ ਕੋਈ ਲਾਗਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਲੈ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੜ੍ਹ ਕੇ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਗਏ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ 1-888-254-2721. ਹੋਰ ਮਦਦ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ 1-800-927-4357 (TTY/TDD: 711)

**Russian**

Доступны бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Вам могут зачитать документы вслух, а некоторые из них могут быть отправлены вам на вашем языке. Если вам нужна помощь, позвоните нам по номеру, указанному на вашей идентификационной карте участника плана, или по номеру 1-888-254-2721. Для получения дополнительной помощи позвоните в Департамент страхования штата California по номеру 1-800-927-4357 (TTY/TDD: 711)

**Tagalog**

Walang Gastos na mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter. Maaari mong ipabasa ang mga dokumento sa iyo at ipadala sa iyo ang ilan sa nang nasa wika mo. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o 1-888-254-2721. Para sa higit pang tulong tumawag sa CA Dept. of Insurance sa 1-800-927-4357 (TTY/TDD: 711)

**Thai**

บริการด้านภาษาแบบไม่เสียค่าใช้จ่าย คุณสามารถรับล่ามเพื่อช่วยเหลือได้ คุณสามารถรับเอกสารแบบมีผู้อ่านให้ฟังและส่งให้คุณในภาษาของคุณได้ หากต้องการความช่วยเหลือ โปรดโทรติดต่อเราตามหมายเลขที่ระบุบนบัตรประจำตัวของคุณหรือ 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดต่อกรมการประกันภัยแห่งแคลิฟอร์เนียได้ที่ 1-800-927-4357 (TTY/TDD: 711)

**Vietnamese**

Dịch vụ Ngôn ngữ Miễn Phí. Quý vị có thể được bố trí thông dịch viên. Quý vị có thể yêu cầu họ đọc tài liệu hoặc gửi cho quý vị một số tài liệu bằng ngôn ngữ của quý vị. Để được trợ giúp, hãy gọi cho chúng tôi theo số điện thoại được ghi trên thẻ ID của quý vị hoặc 1-888-254-2721. Để được trợ giúp thêm, hãy gọi cho Sở Bảo hiểm CA theo số 1-800-927-4357 (TTY/TDD: 711)

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**It's important we treat you fairly**

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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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.