blue california

# Summary of Benefits

**Self-Insured Schools of California**
**Effective October 1, 2026**
**PPO Plan**

## 80% Plan K $30 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 the Claims Administrator pays for Covered Services under the Plan. The Claims Administrator pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

| | | When using a Participating[3] or Non-Participating[4] Provider |
|---|---|---|
| **Calendar Year medical Deductible** | *Individual coverage* | $1,000 |
| | *Family coverage* | $1,000: individual<br>$2,000: 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* | $3,000 |
| *Family coverage* | $3,000: individual<br>$6,000: 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.

Blue Shield of California is an independent member of the Blue Shield Association

| Benefits[6] | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4,9] | CYD[2] applies |
| **Preventive Health Services[7]** | | | | |
| Preventive Health Services | $0 | | Not covered | |
| **Physician services[10]** | | | | |
| Primary care office visit | $30/visit | | 50% | ✔ |
| Specialist care office visit | $30/visit | | 50% | ✔ |
| Physician home visit | $30/visit | | 50% | ✔ |
| Physician or surgeon services in an Outpatient Facility | 20% | ✔ | 50% | ✔ |
| Physician or surgeon services in an inpatient facility | 20% | ✔ | 50% | ✔ |
| **Other professional services[10]** | | | | |
| Other practitioner office visit | $30/visit | | 50% | ✔ |
| *Includes nurse practitioners, physician assistants, and therapists.* | | | | |
| Acupuncture services | 20% | ✔ | 50% | ✔ |
| *Up to 12 visits per Member, per Calendar Year.* | | | | |
| Chiropractic services | 20% | ✔ | 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 | 20% | ✔ | Not covered | |
| Podiatric services | $30/visit | | 50% | ✔ |
| Medical nutrition therapy, not related to diabetes | 20% | ✔ | 50% | ✔ |
| Diagnosis and Treatment of the Cause of Infertility | Not covered | | Not covered | |
| **Pregnancy and maternity care[7,10]** | | | | |
| Physician office visits: prenatal and postnatal | $30/visit | | 50% | ✔ |
| Physician services for pregnancy termination | 20% | ✔ | Not covered | |
| Certified nurse midwives | 20% | ✔ | 20% | ✔ |

| Benefits[6] | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4,9] | CYD[2] applies |
| **Emergency Services** | | | | |
| Emergency room services<br>*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 plus 20% | ✔ | $100/visit plus 20% | ✔ |
| Emergency room Physician services | 20% | ✔ | 20% | ✔ |
| **Urgent care center services[10]** | $30/visit | | 50% | ✔ |
| **Ambulance services**<br>*This payment is for emergency or authorized transport.* | $100/transport plus 20% | ✔ | $100/transport plus 20% | ✔ |
| **Outpatient Facility services** | | | | |
| Ambulatory Surgery Center | 20% | ✔ | All charges above $350 | ✔ |
| Outpatient Department of a Hospital: surgery | 20% | ✔ | All charges above $350 | ✔ |
| Arthroscopy[8] | 20%<br>Subject to a Benefit maximum of $4,500/procedure | ✔ | Not covered | |
| Cataract Surgery[8] | 20%<br>Subject to a Benefit maximum of $2,000/procedure | ✔ | Not covered | |
| Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies | 20% | ✔ | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| **Inpatient facility services** | | | | |
| Hospital services and stay | 20% | ✔ | All charges above $600 | ✔ |
| Transplant services<br>*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 | 20% | ✔ | Not covered | |

| Benefits[6] | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4,9] | CYD[2] applies |
| • Physician inpatient services | 20% | ✔ | Not covered | |
| 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 designated COE is 75 miles or more from the recipient's or donor's place of residence. Coach airfare 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 | 20% | ✔ | Not covered | |
| Outpatient Facility services | 20% | ✔ | Not covered | |
| Physician services | 20% | ✔ | 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. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.* | | | | |
| Laboratory and pathology services | | | | |
| *Includes diagnostic Papanicolaou (Pap) test.* | | | | |
| • Laboratory center | 20% | ✔ | Not covered | |
| • Outpatient Department of a Hospital | 20% | ✔ | Not covered | |
| Basic imaging services | | | | |
| *Includes plain film X-rays, ultrasounds, and diagnostic mammography[11].* | | | | |
| • Outpatient radiology center | 20% | ✔ | Not covered | |
| • Outpatient Department of a Hospital | 20% | ✔ | Not covered | |

| Benefits[6] | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4,9] | CYD[2] applies |
| Other outpatient non-invasive diagnostic testing | | | | |
| *Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.* | | | | |
| • Office location | 20% | ✔ | Not covered | |
| • Outpatient Department of a Hospital | 20% | ✔ | Not covered | |
| Advanced imaging services | | | | |
| *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.* | | | | |
| • Outpatient radiology center | 20% | ✔ | 50% | ✔ |
| • Outpatient Department of a Hospital | 20% | ✔ | 50% Subject to a Benefit maximum of $350/day | ✔ |
| Colonoscopy[8,12] | 20% Subject to a Benefit maximum of $1,500/procedure | ✔ | Not covered | |
| Upper GI Endoscopy[8] | 20% Subject to a Benefit maximum of $1,000/procedure | ✔ | Not covered | |
| Upper GI Endoscopy with Biopsy[8] | 20% Subject to a Benefit maximum of $1,250/procedure | ✔ | Not covered | |
| **Rehabilitative and Habilitative Services** | | | | |
| *Includes physical therapy, occupational therapy, and respiratory therapy.* | | | | |
| Office location | 20% | ✔ | Not covered | |
| Outpatient Department of a Hospital | 20% | ✔ | Not covered | |
| **Speech Therapy services** | | | | |
| Office location | 20% | ✔ | 50% | ✔ |
| Outpatient Department of a Hospital | 20% | ✔ | 50% | ✔ |

| Benefits[6] | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4,9] | CYD[2] applies |
| **Durable medical equipment (DME)** | | | | |
| DME | 20% | ✔ | Not covered | |
| Breast pump | $0 | | Not covered | |
| Orthotic equipment and devices | 20% | ✔ | Not covered | |
| *Up to 2 pairs of shoes and 2 inserts for therapeutic shoes per Calendar Year. Additional 2 pair of orthotics allowed post-surgery* | | | | |
| Prosthetic equipment and devices | 20% | ✔ | 50% | ✔ |
| **Home health care services** | 20% | ✔ | 50% | ✔ |
| *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.* | | | | |
| **Home infusion and home injectable therapy services** | | | | |
| Home infusion agency services | 20% | ✔ | 50% | ✔ |
| *Includes home infusion drugs, medical supplies, and visits by a nurse.* | | | | |
| Hemophilia home infusion services | 20% | ✔ | 50% | ✔ |
| *Includes blood factor products.* | | | | |
| **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 | 20% | ✔ | 20% | ✔ |
| Hospital-based SNF | 20% | ✔ | 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% | ✔ |

| Benefits[6] | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4,9] | CYD[2] applies |
| **Other services and supplies[10]** | | | | |
| Diabetes care services | | | | |
| • Devices, equipment, and supplies | 20% | ✔ | 50% | ✔ |
| • Self-management training | $30/visit | | 50% | ✔ |
| • Medical nutrition therapy | $30/visit | | 50% | ✔ |
| Dialysis services | 20% | ✔ | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| PKU product formulas and special food products | 20% | ✔ | Not covered | |
| Allergy serum billed separately from an office visit | 20% | ✔ | 50% | ✔ |
| Hearing aid services | | | | |
| • Hearing aids and equipment<br>*Up to $700 combined maximum per Member, per 24-month period.* | 20% | ✔ | 20% | ✔ |
| • Audiological evaluations | $30/visit | | 50% | ✔ |

| Mental Health and Substance Use Disorder Benefits | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4,9] | CYD[2] applies |
| **Outpatient services** | | | | |
| Office visit, including Physician office visit | $30/visit | | 50% | ✔ |
| Intensive outpatient care | 20% | ✔ | 50% | ✔ |
| Behavioral Health Treatment in an office setting | 20% | ✔ | 50% | ✔ |
| Behavioral Health Treatment in home or other non-institutional setting | 20% | ✔ | 50% | ✔ |
| Office-based opioid treatment | 20% | ✔ | 50% | ✔ |
| Partial Hospitalization Program | 20% | ✔ | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| Psychological Testing | 20% | ✔ | 50% | ✔ |
| **Inpatient services** | | | | |
| Physician inpatient services | 20% | ✔ | 50% | ✔ |
| Hospital services | 20% | ✔ | All charges above $600 | ✔ |

| Mental Health and Substance Use Disorder Benefits | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4,9] | CYD[2] applies |
| Residential Care | 20% | ✔ | All charges above $600 | ✔ |

## Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Hospice program services
- Inpatient facility 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.

*Covered Services not subject to the Calendar Year medical Deductible.* Some Covered Services received from Participating Providers are paid by the Claims Administrator before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark ( ✔ ) next to them in the "CYD applies" column in the Benefits chart above.

*This benefit Plan has a combined Participating Provider and Non-Participating Provider Calendar Year Deductible.*

*Family coverage has an individual Deductible within the Family Deductible.* This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

## Notes

**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 Deductible or Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.
- 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 and charges above the Allowable Amount.

*Any Deductibles count towards the OOPM.* Any amounts you pay that count towards the Calendar Year medical Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

*This benefit 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;
- Emergency services;
- Certified Nurse Midwives;
- Skilled nursing facilities (SNF) services at a Freestanding SNF; and
- Hearing aids and equipment.

*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 and 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-Participat-ing Provider is a Hospital based Physician performing Services at a 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 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 physician 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.

## Notes

**10 First Dollar Coverage:**

This Plan offers first dollar coverage for 3 office visits with Participating Providers. This means the Claims Administrator will pay for these Covered Services before you are charged a Copayment.

First dollar coverage is available for office visits with a Participating Physician, for any combination of these Provider types:

- General practice
- Family practice
- Internal Medicine
- Pediatrics
- Nurse Practitioner
- Physician's Assistant
- Obstetrics
- Gynecology

After you reach the 3 office visit maximum under the first dollar coverage benefit, additional office visits in the same Calendar Year are subject to the applicable Participating Provider office visit Copayment.

Non-Participating Provider office visits are not covered under the first dollar coverage. These services are covered as described in the Benefits chart above.

**11 Enhanced diagnostic mammogram benefit:**

This Plan offers two diagnostic mammograms for members age 40 and older per Calendar Year with no Copayment, and the Calendar Year Deductible does not apply, when received at a Participating Provider. The applicable Coinsurance and Calendar Year Deductible will apply for any additional diagnostic mammograms.

**12 Enhanced colonoscopy benefit:**

This Plan offers one diagnostic colonoscopy for members age 45 and older per Calendar Year with no Copayment, and the Calendar Year Deductible does not apply, when received at a Participating Ambulatory Surgery Center or Participating Provider's office location. The applicable Coinsurance and Calendar Year Deductible will apply for any additional diagnostic colonoscopy.

Plans may be modified to ensure compliance with Federal requirements.

Pb061626

SISC
Self-Insured Schools of California
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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.