

# CSEBA

## ASO PPO Plan 10/20/35

Outpatient Prescription Drug Coverage  
(For groups of 300 and above)

**THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

## Blue Shield of California

Highlight: \$0 Calendar Year Pharmacy Deductible  
\$10 Tier 1 / \$20 Tier 2 / \$35 Tier 3 Drug – Retail Pharmacy  
\$20 Tier 1 / \$40 Tier 2 / \$70 Tier 3 Drug – Mail Service

Covered Services	Member Copayment
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**DEDUCTIBLES** (Prescription drug coverage benefits are not subject to the medical plan deductible.)

Calendar Year Pharmacy Deductible	\$0 per member per calendar year	
<b>PRESCRIPTION DRUG COVERAGE</b> <sup>1,3,4</sup>	<b>Participating Pharmacy</b>	<b>Non-Participating Pharmacy</b> <sup>7, 8</sup>
Retail Prescriptions (up to a 30-day supply)		
• Contraceptive Drugs and Devices <sup>2</sup>	\$0 per prescription	Applicable Tier 1, Tier 2 or Tier 3 Copayment
• Tier 1 drugs	\$10 per prescription	25% + \$10 per prescription
• Tier 2 drugs	\$20 per prescription	25% + \$20 per prescription
• Tier 3 drugs	\$35 per prescription	25% + \$35 per prescription
• Tier 4 drugs (excluding Specialty drugs)	\$35 per prescription	25% + \$35 per prescription
Mail Service Prescriptions (up to a 90-day supply)		
• Contraceptive Drugs and Devices <sup>2</sup>	\$0 per prescription	Not Covered
• Tier 1 drugs	\$20 per prescription	Not Covered
• Tier 2 drugs	\$40 per prescription	Not Covered
• Tier 3 drugs	\$70 per prescription	Not Covered
• Tier 4 drugs (excluding Specialty drugs)	\$70 per prescription	
Specialty Pharmacies (up to a 30-day supply) <sup>5</sup>		
• Tier 4 - Specialty Drugs <sup>6</sup>	\$35 per prescription	Not Covered

1 Amounts paid through copayments and any applicable pharmacy deductible accrues to the member's medical calendar year out-of-pocket maximum. Please refer to the Plan Contract for exact terms and conditions of coverage. Please note that if you switch from another plan, your prescription drug deductible credit, if applicable, from the previous plan during the calendar year will not carry forward to your new plan.

2 Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will not be subject to the applicable calendar year pharmacy deductible when obtained from a participating pharmacy. If a brand contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic drug equivalent. In addition, select brand contraceptives may need prior authorization to be covered without a copayment.

3 Select drugs require prior authorization by Blue Shield for medical necessity, or when effective, lower cost alternatives are available.

4 If the member requests a brand drug when a tier 1 drug equivalent is available, the member is responsible for paying the difference in cost between the tier 2 drug and its tier 1 drug equivalent, in addition to the tier 1 drug copayment. The difference in cost that the member must pay does not accrue to any calendar year medical or tier 2 drug deductible and is not included in the calendar year out-of-pocket maximum responsibility calculations. Refer to the Plan Contract for details

5 Network Specialty Pharmacies dispense Specialty drugs which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacies also dispense Specialty drugs requiring special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty drugs are generally high cost.

6 Specialty drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides specialty drugs by mail or upon member request, at an associated retail store for pickup.

7 To obtain prescription drugs, including contraceptive drugs and devices, at a non-participating pharmacy, the member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. The member will be reimbursed the price paid for the drug less any applicable deductible, copayment or coinsurance and any applicable out of network charge.

8 Outpatient prescription drug copayments for covered drugs obtained from non-participating pharmacies will accrue to the calendar year medical deductible and the participating provider maximum calendar year out-of-pocket maximum.

Note: This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the Federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this

coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

## Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Plan Contract*.
2. Go to <https://www.blueshieldca.com/bsca/pharmacy/home.sp> and log onto My Health Plan from the home page.
3. Call Member Services at the number listed on your Blue Shield member ID card.

At Blue Shield of California, we're dedicated to providing you with valuable resources for managing your drug coverage. Go online to the *Pharmacy* section of <https://www.blueshieldca.com/bsca/pharmacy/home.sp> and select the *Drug Database and Formulary* to access a variety of useful drug information that can affect your out-of-pocket expenses, such as:

- Look up non-formulary drugs with formulary or generic equivalents;
- Look up drugs that require step therapy or prior authorization;
- Find specifics about your prescription copayments;
- Find local network pharmacies to fill your prescriptions.

### TIPS!

Using the convenient mail service pharmacy can save you time and money. If you take a consistent dose of a covered maintenance drug for a chronic condition, such as diabetes or high blood pressure, you can receive up to a 90-day supply through the mail service pharmacy with a reduced copayment. Call the mail service pharmacy at (866) 346-7200. Members using TTY equipment can call TTY/TDD 866-346-7197.

Plan designs may be modified to ensure compliance with Federal requirements.  
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