

CCPOA (Basic Plan)  
 Custom Access+ HMO Plan

Outpatient Prescription Drug Coverage  
 (For groups of 101 and above)

**THIS DRUG COVERAGE SUMMARY IS ADDED TO BE COMBINED WITH THE HMO OR POS PLANS UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

**Blue Shield of California**

**Highlight: \$50 per member/\$150 per family Calendar Year Pharmacy Deductible**  
**\$10 Tier 1 /\$25 Tier 2 /\$50 Tier 3 drug - Retail Pharmacy**  
**\$20 Tier 1 /\$50 Tier 2 /\$100 Tier 3 drug - Mail Service**

Covered Services	Member Copayment
<b>DEDUCTIBLES</b>	
<small>(Prescription drug coverage benefits are not subject to the medical plan deductible)</small>	
<b>Calendar Year Pharmacy Deductible</b>	\$50 per member / \$150 per family per calendar year
<small>(Applicable to all covered drugs not in Tier 1. Does not apply to Contraceptive drugs and devices or oral anticancer drugs.)</small>	
<b>PRESCRIPTION DRUG COVERAGE<sup>1,2,3,4</sup></b>	
	<b>Participating Pharmacy<sup>5</sup></b>
<b>Pharmacy Network:</b> Rx Ultra	
<b>Drug Formulary:</b> Plus Formulary	
Retail Prescriptions (up to a 30-day supply)	
• Contraceptive drugs and devices <sup>6</sup>	\$0 per prescription
• Tier 1 drugs	\$10 per prescription
• Tier 2 drugs	\$25 per prescription
• Tier 3 drugs	\$50 per prescription
• Tier 4 drugs (excluding Specialty drugs)	\$50 per prescription
Mail Service Prescriptions (up to a 90-day supply)	
• Contraceptive drugs and devices <sup>6</sup>	\$0 per prescription
• Tier 1 drugs	\$20 per prescription
• Tier 2 drugs	\$50 per prescription
• Tier 3 drugs	\$100 per prescription
• Tier 4 drugs (excluding Specialty drugs)	\$100 per prescription
Specialty Pharmacies (up to a 30-day supply) <sup>7</sup>	
• Tier 4 - Specialty drugs <sup>8</sup>	\$50 per prescription

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 *Evidence of Coverage* and 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 Drugs obtained at a non-participating pharmacy are not covered, unless Medically Necessary for a covered emergency.

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 generic drug equivalent is available, the member is responsible for paying the Tier 1 drug copayment plus the difference in cost to Blue Shield between the brand drug and its generic drug equivalent.

5 Coinsurance is calculated based on the contracted rate. When the Participating Pharmacy's contracted rate is less than the Member's Copayment or Coinsurance, the Member only pays the contracted rate.

6 Contraceptive drugs and devices covered under the outpatient prescription drug benefits will not be subject to the 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 contraceptives may need prior authorization to be covered without a copayment. The member may receive up to a 12-month supply of contraceptive Drugs.

7 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.

8 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. Oral anticancer medications are not subject to the calendar year pharmacy deductible.

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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 83 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you would 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 *Evidence of Coverage*.
2. Go to [www.blueshieldca.com/bsca/pharmacy/home.sp](http://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 [www.blueshieldca.com/bsca/pharmacy/home.sp](http://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 prescription.

### **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 711.

Plan designs may be modified to ensure compliance with state and Federal requirements

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PENDING REGULATORY APPROVAL