

Mendocino County Schools/Staywell Plan

ASO PPO Plan - Retiree

Outpatient Prescription Drug Coverage

(For groups of 300 and above)

Blue Shield of California

Highlight: \$150 Contract Year Pharmacy Deductible
 \$10 Tier 1 / \$30 Tier 2 / \$50 Tier 3 Drug – Retail Pharmacy
 \$20 Tier 1 / \$60 Tier 2 / \$100 Tier 3 Drug – Mail Service

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

Covered Services	Member Copayment
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DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible.)
Contract Year Pharmacy Deductible \$150 per member per contract year

PRESCRIPTION DRUG COVERAGE ^{1,3,4}	Participating Pharmacy	Non-Participating Pharmacy ^{7,8}
Retail Prescriptions (up to a 30-day supply)		
• Contraceptive Drugs and Devices ²	\$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	\$30 per prescription	25% + \$30 per prescription
• Tier 3 drugs	\$50 per prescription	25% + \$50 per prescription
• Tier 4 drugs (excluding Specialty drugs)	20% (up to \$150 coinsurance maximum per prescription)	Not Covered
Mail Service Prescriptions (up to a 90-day supply)		
• Contraceptive Drugs and Devices ²	\$0 per prescription	Not Covered
• Tier 1 drugs	\$20 per prescription	Not Covered
• Tier 2 drugs	\$60 per prescription	Not Covered
• Tier 3 drugs	\$100 per prescription	Not Covered
• Tier 4 drugs (excluding Specialty drugs)	20% (up to \$300 coinsurance maximum per prescription)	Not Covered
Specialty Pharmacies (up to a 30-day supply) ⁵		
• Tier 4 - Specialty Drugs ⁶	20% (up to \$150 maximum per prescription)	Not Covered

1 Amounts paid through copayments and any applicable pharmacy deductible does not accrue to the member's medical contract 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 contract 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 contract 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 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. The difference in cost that the member must pay does not accrue to any contract year medical or tier 2 drug deductible and is not included in the contract 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 contract year medical deductible and the participating provider maximum contract 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.

ASO (1/19) PB 050119



Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
 - Qualified sign language interpreters
 - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human
Services 200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language Access Services

English: For assistance in English at no cost, call 1-866-346-7198

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulong sa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码 1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo ɓaah ílínígó shíka' at'ooowól nínízingo, kwijí' hodiílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이 필요하시면, 1-866-346-7198 무료전화 로 전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնամարխնարում ենք Ձանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合、1-866-346-7198 に電話をかけてください。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی، لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵੱਲੋਂ ਮੁਫਤ ਕਾਲ ਕਰੋ: 1-866-346-7198

Khmer (ភាសាខ្មែរ): សូមទំនួលទាញអាស៊ានអង្គការសុខភាពសាធារណៈ 1-866-346-7198.

Arabic (العربية): للحصول على المساعدة في اللغة العربية مجاناً، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198.