

High Desert & Inland Trust
Premier PPOSM Plans
Outpatient Prescription Drug Coverage
(For groups of 300 and above)

Blue Shield of California

Highlight: 3-Tier/Incentive Formulary
No Calendar-Year Brand-Name Drug Deductible
\$8 Generic/\$20 Formulary Brand-Name/\$35 Non-Formulary Brand-Name Drugs - Retail Pharmacy
\$8 Generic/\$30 Formulary Brand-Name/\$50 Non-Formulary Brand-Name Drugs - Mail Service

THIS DRUG SUMMARY IS INTENDED TO BE USED WITH THE SHIELD SPECTRUM PPO PLANS UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX. THE EVIDENCE OF COVERAGE, DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Effective Date July 1, 2008

Covered Services

Member Copayment

DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible.)

Calendar-year brand-name drug deductible

None

PRESCRIPTION DRUG COVERAGE^{1,2}

(Includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)

	Participating Pharmacy	Non-Participating Pharmacy
		Member pays 25% of allowable amount plus a copayment of:
Retail prescriptions (For up to a 30-day supply)		
• Generic	\$8/prescription	\$8/prescription
• Formulary brand-name	\$20/prescription	\$20/prescription
• Non-formulary brand-name	\$35/prescription	\$35/prescription
Mail service prescriptions (For up to a 90-day supply)		
• Generic	\$8/prescription	Not covered
• Formulary brand-name	\$30/prescription	Not covered
• Non-formulary brand-name	\$50/prescription	Not covered
Home self-administered injectable medications (May require prior authorization from Blue Shield Pharmacy Services; not covered through mail service benefit)	30% (Up to \$150 copayment maximum per prescription) ²	Not covered

1 Copayments and charges for these covered services are not included in the calculation of the member's medical calendar-year copayment maximum and continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the Evidence of Coverage and the Plan Contract for exact terms and conditions of coverage.

2 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of California of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs obtained from a Non-Specialty Pharmacy Network are not covered, unless Medically Necessary for a covered emergency.

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). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D 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 before enrolling in Medicare Part D you could be subject to payment of higher Part D premiums.

Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Evidence of Coverage*.
2. Go to **blueshieldca.com** 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 **blueshieldca.com** 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 drugs with generic equivalents;
- Look up drugs that require 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 state and federal requirements. A16154-d PC (07/08)