Anthem

Capital Area Health Consortium
Prescription Drug Program
$10 Copayment Generic Drugs
$20 Copayment Brand-Name Drugs
Unlimited Annual Maximum

Description of Benefits		***You Pay:***
Tier 1: Generic Drugs	The term "generic" refers to a prescription drug that is considered non-proprietary and is not protected by a trademark. It is required to meet the same bioequivalency test as the original brand-name drug. Tier 1 copayment applies.	$10
Tier 2: Brand-Name Drugs	This category refers to covered prescription drugs that are sold using a commercial name rather than a generic name. For example, Prozac, the antidepressant, is a brand-name for Fluoxetine, the generic equivalent. Tier 2 copayment applies.	$20

		Plan Pays:
Annual Maximum	Per member per calendar year	Unlimited

How To Use The 2-Tier Managed Prescription Drug Program

The 2-Tier Managed Prescription Drug Program incorporates two different levels of copayments: one for generic, and one for brand-name prescription drugs, as defined in the chart above. You minimize your copayments when you use generic prescriptions. You'll still have coverage for brand-name drugs, but at a higher cost share. **Talk to your provider** about using generic drugs. You'll have lower copayments when you use these drugs.

- You will be responsible for **one** copayment when purchasing a **34-day supply** of prescription drugs from a participating retail pharmacy.
- You'll be responsible for **0** copayments when purchasing **a 35-day to 100-day supply** of maintenance drugs through the mail-order program.

Generic Substitution: Prescriptions may be filled with the generic equivalent when available.

- When you purchase a generic drug at a participating pharmacy, you'll only be responsible for a Tier 1 copayment.
- When a generic equivalent is available and you obtain a brand-name drug, you will be responsible for the brand-name copayment *plus* the difference in cost between the generic and brand-name drug. This provision applies unless your provider obtains Prior Authorization. When Prior Authorization is obtained (at the discretion of Anthem Blue Cross and Blue Shield), you will be responsible only for the brand-name copayment.

Connection (Concurrent Drug Utilization Review)

Connection works with the retail pharmacy's standard guidelines to provide a **second level of quality and safety checks**. The process, which is provided on-line as part of the electronic claims filing process, helps promote access to safe, appropriate, cost-effective medications for members. Connection involves a series of rules or guidelines, which identify potential medication therapy issues and deliver a message to the pharmacy by computer before the medication is dispensed. The process alerts the pharmacist of potential issues such as drug-to-drug interactions, refills requested too close together, incorrect dosing or drug duplications.

Anthem

Pharmacy Programs

Home Delivery Pharmacy

Home delivery is for people who take medications on an ongoing basis. Our preferred home delivery pharmacy, operated by Express Scripts, delivers the medications you need, right to your door. You can easily refill home delivery prescriptions by phone, fax, mail or online and view benefit information 24/7 at anthem.com

When ordering a **35-day to 100-day supply, 0** copayments will apply.

Retail Pharmacies

Our retail pharmacy network includes more than 62,000 pharmacies throughout the United States. That means you have convenient access to your prescriptions wherever you are – at home, work or even on vacation. To find out if your pharmacy participates in our network, contact Customer Care at the phone number listed on your member ID card or visit anthem.com for a list of participating pharmacies.

Non-participating Pharmacies

Members who fill prescriptions at a non-participating pharmacy are responsible for payment at the time the prescription is filled. Members must submit claims to Anthem Blue Cross and Blue Shield for reimbursement, and payment will be sent to the member. Members who use non-participating pharmacies will pay 20% of the in-network allowance, plus the difference between Anthem Blue Cross and Blue Shield's payment and the pharmacist's actual charge.

Points to Remember

- Anthem Blue Cross and Blue Shield will provide coverage for prescription drugs dispensed by a participating pharmacy when prescription drugs are deemed medically necessary based on specific criteria and dispensed pursuant to a prescription issued by a participating physician or by a non-participating physician, subject to copayment.
- Anthem Blue Cross and Blue Shield will not be liable for any injury, claim or judgment resulting from the dispensing of any drug covered by this plan. Anthem Blue Cross and Blue Shield will not provide benefits for any drug prescribed or dispensed in a manner contrary to normal medical practice.
- Anthem Blue Cross and Blue Shield reserves the right to apply quantity limits to specified drugs as listed on the formulary. If a member requires a greater supply, the member's provider can follow the prior authorization process.

Prescription Drug Eligibility

Eligible prescription drug benefits are limited to injectable insulin and those drugs, biologicals, and compounded prescriptions that are required to be dispensed only according to a written prescription, and included in the United States Pharmacopoeia, National Formulary, or Accepted Dental Remedies and New Drugs, and which, by law, are required to bear the legend: "Caution—Federal Law prohibits dispensing without a prescription" or which are specifically approved by the Plan.

Limits and Exclusions

*Benefits are limited to no more than a **34-day supply** for covered drugs purchased at a retail pharmacy, and no more than a **100-day supply** for covered drugs purchased by mail order. All prescriptions are subject to the quantity limitations imposed by state and federal statutes.*

This drug rider does not provide drugs dispensed by other than a licensed, retail pharmacy or our mail-order service; any drug not required for the treatment or prevention of illness or injury; vaccines or allergenic extracts; devices and appliances; needles and syringes that are not prescribed by a provider for the administration of a covered drug; prescriptions dispensed in a hospital or skilled nursing facility; over-the-counter or non-legend drugs; antibacterial soaps/detergents, shampoos, toothpastes/gels and mouthwashes/rinse.

Benefits for prescription birth control are covered for most groups. However, such coverage is optional if your group is self-insured or a bona fide religious organization. Check with your benefits administrator.

This is not a legal contract. It is only a general description of the $10 generic/$20 brand-name 2-Tier Managed Prescription Drug Program with an Unlimited annual maximum. Please consult the Evidence of Coverage or prescription drug rider for a complete description of benefits and exclusions applicable to your coverage.

EXPRESS SCRIPTS®

HOME DELIVERY PHARMACY ORDER FORM

To MAIL your prescription:
1. "Patient" box must be filled out.
2. Have your Doctor write a prescription.
3. Send your new prescription along with this completed form to:
   Express Scripts Home Delivery Service
   PO Box 66785
   St. Louis MO 63166-6785

To FAX your prescription:
1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-800-600-8105
   - **Class II prescriptions cannot be faxed.**
   - Faxes will only be accepted from a doctor's office.

PATIENT

Member ID: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

Address: _____

_____

_____

E-mail: _____

Allergies: _____

_____

Health Conditions: _____

_____

_____

Over-the-Counter Medications: _____

_____

DOCTOR/PRESCRIBER

DEA: _____

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

PATIENT OPTIONS

☐ I want non-child resistant caps, when available.
☐ I want a copy of my bottle label in large print on a separate sheet of paper.
☐ Check here for rush delivery. Once your order is received and filled, it will be shipped overnight for $21.

If you want to make a payment or update your health conditions, please visit your health plan provider's website.

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Rx

_____ _____ **Date:** __ __ / __ __ / __ __
First Name **Last Name**

Drug Name/Form/Strength	Qty	Directions for Use	Refills

X _____
Doctor/Prescriber Signature – Substitution Permissible

X _____
Doctor/Prescriber Signature – Dispense as Written

Stamped signatures cannot be accepted.