

**BLUECARE BASIC \$5,000 / \$10,000 CALENDAR YEAR DEDUCTIBLE  
\$30/ \$45 OV COPAYMENT**

**BlueCare Basic is a health maintenance organization (HMO) plan that features a primary care physician (PCP) who works with you to coordinate your health care. PCP referrals are not required to receive care from a specialist provider.**

<b>COST SHARE PROVISIONS</b>	<b>In-Network Member pays:</b>
Office Visit ( <b>OV</b> ) Copayment	\$30 per visit
Specialist Visit ( <b>SV</b> ) Copayment	\$45 per visit
Inpatient Hospital / Outpatient Surgery Calendar Year Deductible ( <i>individual / family</i> )	\$5,000 / \$10,000
Urgent Care ( <b>UR</b> ) Copayment	\$75
Emergency Room ( <b>ER</b> ) Copayment – <i>waived if admitted</i>	\$150
Lifetime Maximum	Unlimited

**PREVENTIVE CARE - Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits**

Well child care <i>Birth to 12 years</i> <i>All others</i>	No Charge No Charge
Periodic, routine health examinations	No Charge
Routine OB/GYN visits	No Charge
Mammography	No Charge
Hearing screening	No Charge

**MEDICAL CARE**

Office visits <i>PCP</i> <i>Specialist</i>	OV Copayment SV Copayment
Outpatient mental health & substance abuse – <i>prior authorization required</i>	SV Copayment
OB/GYN care	SV Copayment
Surgical fees of a Physician or Surgeon	OV/SV Copayment*
Maternity care – <i>initial physician visit subject to copayment, no charge thereafter</i>	Physician: SV Copayment Hospital: No Charge after Deductible
Diagnostic lab - In an outpatient hospital setting - In an office or reference laboratory	OV Copayment No Charge
Diagnostic x-ray	OV/SV Copayment*
High-cost outpatient diagnostic – <i>prior authorization required</i> <i>The following are subject to copay: MRI, MRA, CAT, CTA, PET, SPECT scans</i>	\$75 Copayment per service \$375 Copayment Maximum per Member per Calendar Year
Allergy services <i>Office visits/testing</i> <i>Injections—80 visits in 3 years</i>	SV Copayment \$25 Copayment

**HOSPITAL CARE – Prior authorization required**

Semi-private room ( <i>General/Medical/Surgical/Maternity</i> )	No Charge after Deductible
Inpatient mental health & substance abuse	No Charge after Deductible
Skilled nursing facility – <i>up to 90 days per calendar year</i>	No Charge after Deductible
Rehabilitative services – <i>up to 60 days per person per calendar year</i>	No Charge after Deductible
Outpatient surgery – <i>in a hospital</i>	No Charge after Deductible
Ambulatory surgery – <i>in other than a hospital setting</i>	No Charge after Deductible

<b>EMERGENCY CARE</b>	<b>In-Network Member pays:</b>
Walk-in centers	OV Copayment
Urgent care – <i>at participating centers only</i>	UR Copayment
Emergency care – <i>copayment waived if admitted</i>	ER Copayment
Ambulance	No Charge

<b>VISION CARE</b>	
Vision exam – <i>one every 12 months</i>	\$20 Copayment
Standard Plastic Lenses – <i>once every 24 months **</i>	\$20 Copayment
Frames – <i>once every 24 months</i> <i>\$120.00 maximum when the provider is in-network</i>	Charges in excess of maximum payable amount
Contact lenses – <i>once every 24 months**</i> <i>Elective - \$105.00 maximum when provider is in-network (in lieu of frame/lens)</i> <i>Non-Elective - Paid in full when provider is in-network; \$210.00 maximum when provider is out-of-network</i>	

<b>OTHER HEALTH CARE</b>	
Outpatient rehabilitative services - <i>Prior authorization required after the first visit for PT and OT</i> <i>30 combined visit maximum for PT, OT and ST per calendar year. 20 visit maximum for Chiro. per calendar year.</i>	SV Copayment
Durable medical equipment / Prosthetic devices <i>Unlimited maximum per calendar year</i>	50%
Diabetic supplies, drugs & equipment	50%
Infertility services – <i>prior authorization required</i> <i>Some restrictions may apply</i>	Applicable Copayment
Home health care <i>100 visit limit per member per calendar year</i>	OV Copayment

**PREVENTIVE CARE SCHEDULES**

<b>Well Child Care</b> <i>(including immunizations)</i>
◆ 7 exams, birth up to age 1
◆ 7 exams, ages 1 up to 5
◆ 1 exam every year, ages 5 up to 22

<b>Adult Exams</b>
◆ 1 exam every year, ages 22 +

<b>Mammography</b>
◆ 1 baseline screening, ages 35 – 39
◆ 1 screening per year, ages 40+
◆ Additional exams when medically necessary

<b>Vision Exams:</b> 1 exam every 2 calendar years
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<b>Hearing Exams:</b> 1 exam per calendar year
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<b>OB/GYN Exams:</b> 1 exam per calendar year
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**Notes To Benefit Descriptions**

- ◆ In situations where the member is responsible for obtaining the necessary prior authorization and fails to do so, benefits may be reduced or denied.
- ◆ Members must utilize participating Blue Quality Centers for Transplant hospitals to receive benefits for Human Organ & Tissue Transplant services. This network of the finest medical transplant programs in the nation is available to members who are candidates for an organ or bone marrow transplant. A nurse consultant trained in case management is dedicated to managing members who require organ and/or tissue transplants.
- \* Copayment depends on if provider is a PCP or Specialist. The SV Copayment applies to Diagnostic x-ray in an outpatient hospital setting.
- \*\* Lens or contact benefit may be used once every 24 months.

Please refer to the *SpecialOffers@Anthem* brochure in your enrollment kit for information on the discounts we offer on health-related products and services.



*This does not constitute your health plan or insurance policy. It is only a general description of the plan. The following are examples of services NOT covered by your BlueCare Basic Health Plan. Please refer to your Subscriber Agreement/Certificate of Coverage/Summary Booklet for more details: Cosmetic surgeries and services; custodial care; genetic testing; hearing aids; refractive eye surgery; services and supplies related to, as well as the performance of, sex change operations; surgical and non-surgical services related to TMJ syndrome; travel expenses; vision therapy; services rendered prior to your contract effective date or rendered after your contract termination date; and workers' compensation.*

*This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.*

A product of Anthem Blue Cross and Blue Shield serving residents and businesses in the State of Connecticut

NGF  
Effective 1/1/12

**BLUECARE 3-TIER PRESCRIPTION DRUG PROGRAM**

**\$10 Copayment Tier 1 Drugs**

**\$25 Copayment Tier 2 Drugs**

**\$40 Copayment Tier 3 Drugs**

**Unlimited Annual Maximum**

**Description of Benefits**

**You Pay:**

<b>Tier 1</b>	Tier 1 drugs have the lowest copayment. This tier will contain low cost or preferred medications that may be generic, single source brand drugs, or multi-source brand drugs. Tier 1 copayment applies.	\$10
<b>Tier 2</b>	Tier 2 drugs will have a higher copayment than those in Tier 1. This tier will contain preferred medications that may be generic, single source, or multi-source brand drugs. Tier 2 copayment applies.	\$25
<b>Tier 3</b>	Tier 3 drugs will have a higher copayment than those on Tier 2. This tier will contain non-preferred and high cost medications. This tier will include medications considered generic, single source, or multi-source brand drugs. Tier 3 copayment applies.	\$40

**Plan Pays:**

<b>Annual Maximum</b>	Per member per calendar year	Unlimited
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**How To Use The 3-Tier Prescription Drug Program**

The 3-Tier Prescription Drug Program incorporates different levels of copayments for three types of prescription drugs as defined in the chart above. The formulary lists generics and brand-name drugs that have been selected for their quality, safety and cost-effectiveness. These preferred drugs may have lower member copayments than non-preferred drugs (but may not have a lower overall cost in all instances.) You may minimize your copayments when you use preferred generic prescriptions and preferred brand-name prescriptions. You'll still have coverage for non-preferred generic and brand-name drugs, but at a higher cost share. **Talk to your provider** about using preferred generic drugs or preferred brand-name drugs included on the formulary. You'll have lower copayments when you use these drugs.

- You will be responsible for **one** copayment when purchasing a **30-day supply** of prescription drugs from a participating retail pharmacy.
- You'll be responsible for **one or two** copayments when purchasing a **31-day to 90-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 preferred 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 preferred or non-preferred brand-name drug, you will be responsible for the applicable Tier copayment *plus* the difference in cost between the generic and preferred or non-preferred 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 applicable Tier 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.

## Pharmacy Programs

### Voluntary Mail-service Program

Members have access to Anthem's mail service pharmacy, the voluntary mail-service drug program for members who regularly take one or more types of maintenance drugs. Members can order up to a **90-day supply** of these medications and have them delivered directly to their home.

The \$10 Tier 1 / \$25 Tier 2 / \$40 Tier 3 copayment and unlimited annual maximum apply. When ordering a **31-day to 90-day supply**, **copayments** will apply as follows: \$10 Tier 1 / \$50 Tier 2 / \$80 Tier 3.

### National Pharmacy Network

Members also have access to a network of more than 65,000 retail pharmacies throughout the country. Members may call 1-800-962-8192, or go to [www.wellpointnextrx.com](http://www.wellpointnextrx.com) to locate a participating pharmacy when traveling outside the state.

### Emergencies Outside the Service Area – Non-participating Pharmacies

The Plan will make payments for prescription drugs dispensed at a non-participating pharmacy outside of the service area; however, payment will be made only for treatment of an accident or emergency illness incurred outside of the service area, subject to approval by the Plan. Members must submit an itemized sales slip to the Plan for reimbursement within 120 days from the date of purchase.

### 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 **30-day supply** for covered drugs purchased at a retail pharmacy, and no more than a **90-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 Tier 1 / \$25 Tier 2 / \$40 Tier 3 3-Tier Prescription Drug Program with an unlimited annual maximum. Please consult the subscriber agreement or prescription drug rider for a complete description of benefits and exclusions applicable to your coverage.*