Anthem BlueCross BlueShield

CENTURY PREFERRED $15/$0/$35/$0

Century Preferred is a preferred provider organization (PPO) plan.

COST SHARE PROVISIONS	**In-Network** *Member pays:*	**Out-of-Network** *Member pays:*
Office Visit (**OV**) Copayment	$15 per visit	Deductible & Coinsurance
Specialist Visit (**SV**) Copayment	$15 per visit	Deductible & Coinsurance
Hospital (**HSP**) Copayment	$0	Deductible & Coinsurance
Urgent Care (**UR**) Copayment	$15	Not Covered
Emergency Room (**ER**) Copayment – *waived if admitted*	$35	$35
Outpatient Surgery (**OS**) Copayment	$0	Deductible & Coinsurance
Ambulatory Surgery (**ASC**) Copayment	$0	Deductible & Coinsurance
Annual Deductible (*individual/2-member family/3+ member family*)	Not Applicable	$300/$600/$900
Coinsurance		20% after deductible up to
Coinsurance Maximum (*individual/2-member family/3+ member family*)		$1700/$3400/$3100
Cost Share Maximum *(individual/2-member family/3+member family)****	$6,850/$13,700/$13,700	$2000/$4000/$4000
Lifetime Maximum	Unlimited	Unlimited

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

Well child care	No Charge	Deductible & Coinsurance
Periodic, routine health examinations	No Charge	
Routine OB/GYN visits	No Charge	
Mammography	No Charge	
Hearing screening	OV Charge	

MEDICAL CARE

Office visits *Primary Care* *Specialist*	 OV Copayment SV Copayment	Deductible & Coinsurance
Outpatient mental health & substance abuse	OV Copayment	
OB/GYN care	SV Copayment	
Surgical fees of a Physician or Surgeon	No Copayment	
Maternity care – *initial visit subject to copayment, no charge thereafter*	SV Copayment	
Diagnostic lab - In an outpatient hospital setting - In an office or reference laboratory	 No Copayment No Charge	
Diagnostic x-ray	No Copayment	
High-cost outpatient diagnostic *The following are not subject to a copay: MRI, MRA, CAT, CTA, PET, SPECT scans*	No Copayment	
Allergy services *Office visits/testing* *Injections—Unlimited*	 SV Copayment $0 Copayment	

HOSPITAL CARE – *Prior authorization required*

Semi-private room *(General/Medical/Surgical/Maternity)*	HSP Copayment	Deductible & Coinsurance
Inpatient mental health & substance abuse	HSP Copayment	
Skilled nursing facility – *unlimited days per calendar year in network/ 60 days out of network*	HSP Copayment	
Rehabilitative services – *unlimited days per calendar year*	No Charge	
Outpatient surgery – *in a hospital*	No Copayment	
Ambulatory surgery – *in other than a hospital setting*	No Copayment	

EMERGENCY CARE

Walk-in centers	OV Copayment	Deductible & Coinsurance
Urgent care – *at participating centers only*	UR Copayment	Not Covered
Emergency care – *copayment waived if admitted*	ER Copayment	ER Copayment
Ambulance	No Charge	No Charge

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OTHER HEALTH CARE	In-Network *Member pays:*	Out-of-Network *Member pays:*
Outpatient rehabilitative services – PT/OT/ST/Chiropractic *Unlimited maximum per calendar year*	No Copayment	Deductible & Coinsurance
Acupuncture – *20 visits/year*	SV Copay	Deductible & Coinsurance
Nutritional Counseling – *3 visits/year*	No Copayment	Deductible & Coinsurance
Durable medical equipment / Prosthetic devices *Unlimited maximum per calendar year*	No Copayment	Deductible & Coinsurance
Diabetic supplies, drugs & equipment *Diabetic drugs are covered at in-network benefit level.*	Covered	
Infertility services – *Covered*	Applicable Copayment	Deductible & Coinsurance
Home health care *200 visits per member per calendar year with 80 Home Health Aide visits*	No Copayment	$50 Deductible & 20 % Coinsurance

PREVENTIVE CARE SCHEDULES

Mammography

- 1 baseline screening, ages 35 – 39
- 1 screening per year, ages 40+
- Additional exams when medically necessary

Vision Exams: 1 exam every calendar year – OV Copay

Hearing Exams: 1 exam per calendar year – OV Copay

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.
- Inpatient Hospital Per Admission Copay is waived if readmitted within 30 days for same diagnosis. Maximum of 3 copays per person per year.
- 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.
- For services rendered by out-of-network providers, members are responsible for paying any charges in excess of the Maximum Allowable Amount. Please reference your Subscriber Agreement/Certificate of Coverage for additional details.

* The In-Network Cost Share Maximum represents: In Network copays and applicable In-Network Coinsurance. Once the In-Network Cost Share Maximum is reached the plan will pay In-Network copay and cost share services at 100% for the remainder of the plan or calendar year.
*Copayment depends on if provider is a PCP or Specialist. The SV Copayment applies to Diagnostic x-ray in an outpatient hospital setting.

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 Century Preferred 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.

Anthem BlueCross BlueShield

CENTURY PREFERRED 3-TIER MANAGED PRESCRIPTION DRUG PROGRAM

$5 Copayment Tier 1 Drugs
$10 Copayment Tier 2 Drugs
$25 Copayment Tier 3Drugs
Unlimited Annual Maximum

Description of Benefits		***You Pay:***
Tier 1	Tier 1 drugs have the lowest copayment. This tier contains low cost or preferred medications that may be generic, single source brand drugs, or multi-source brand drugs.	$5
Tier 2	Tier 2 drugs will have a higher copayment than those in Tier 1. This tier contains preferred medications that may be generic, single source, or multi-source brand drugs.	$10
Tier 3	Tier 3 drugs will have a higher copayment than those on Tier 2. This tier contains non-preferred and high cost medications. This tier will include medications that may be generic, single source, or multi-source brand drugs.	$25

		Plan Pays:
Annual Maximum	Per member per calendar year	Unlimited

How To Use The 3-Tier Managed Prescription Drug Program

The 3-Tier Managed Prescription Drug Program incorporates different levels of copayments for prescription drugs as defined in the chart above. The formulary lists drugs that have been selected for their quality, safety and cost-effectiveness. These preferred drugs 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 medications. You'll still have coverage for non-preferred drugs, but at a higher cost share. **Talk to your provider** about using preferred drugs 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** copayment when purchasing **a 31-day to 90-day supply** of maintenance drugs through the mail-order pharmacy.

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

- When a generic equivalent is available and you obtain a preferred or non-preferred brand-name drug, you will be responsible for the Tier 1 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 applicable Tier copayment.
- Prior authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. The PBM uses pre-approved criteria, developed by our Pharmacy and Therapeutics Committee, which is reviewed and adopted by us.
- Step therapy may be required for certain Prescription Drugs. Step therapy refers to the process in which you may be required to use one type of medication before benefits are available for another.

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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

The $5 Tier 1 /$10 Tier 2 /$25 Tier 3 copayment and unlimited annual maximum apply. When ordering a **31-day to 90-day supply, one copayment** will apply as follows: $5 Tier 1 /$10 Tier 2 /$25 Tier 3.

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 **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 $5 Tier 1 /$10 Tier 2 /$25 Tier 3 3-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.