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BLUECARE BASIC POS $5,000-$10,000 DEDUCTIBLE
$30 / $45 OV COPAYMENT

BlueCare POS is a point-of-service (POS) 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.

COST SHARE PROVISIONS	**In-Network** *Member pays:*	**Out-of-Network** *Member pays:*
Office Visit (**OV**) Copayment	$30 per visit	Deductible & Coinsurance
Specialist Visit (**SV)** Copayment	$45 per visit	Deductible & Coinsurance
Inpatient Hospital/Outpatient Surgery Calendar Year Deductible	$5,000 / $10,000	Deductible & Coinsurance
Urgent Care (**UR**) Copayment	$75	Not Covered
Emergency Room (**ER**) Copayment – *waived if admitted*	$150	$150
Calendar Year Deductible (*individual/2+ member family*)	Not Applicable	$6,000/$12,000
Coinsurance		30% after deductible up to
Coinsurance Maximum (*individual/2+ member family*)		$6,000/$12,000
Cost Share Maximum *(individual/2+ member family)*		$12,000/$24,000
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 *Birth to 12 years* *All others*	 No Charge No Charge	Not Covered
Periodic, routine health examinations	No Charge	
Routine OB/GYN visits	No Charge	Deductible & Coinsurance
Mammography	No Charge	
Hearing screening	No Charge	

MEDICAL CARE

Office visits *PCP* *Specialist*	 OV Copayment SV Copayment	Deductible & Coinsurance
Outpatient mental health & substance abuse *Prior authorization required*	SV Copayment	
OB/GYN care	SV Copayment	
Surgical fees of a Physician or Surgeon	OV/SV 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	 OV Copayment No Charge	
Diagnostic x-ray	OV/SV Copayment*	
High-cost outpatient diagnostic – *prior authorization required* *The following are subject to copay: MRI, MRA, CAT, CTA, PET, SPECT scans* **Note:** *$375 Copayment Maximum per Member per Calendar Year*	$75 Copayment per service (See note)	
Allergy services *Office visits/testing* *Injections—80 visits in 3 years*	 SV Copayment $25 Copayment	

HOSPITAL CARE – *Prior authorization required*

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

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EMERGENCY CARE	In-Network *Member pays:*	Out-of-Network *Member pays:*
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

VISION CARE

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

OTHER HEALTH CARE

Outpatient rehabilitative services – *Prior authorization required after the first visit for PT and OT* *30 combined visit maximum for PT, OT and ST and 20 visit maximum for Chiro. per calendar year*	SV Copayment	Deductible & Coinsurance
Durable medical equipment / Prosthetic devices *Unlimited maximum per calendar year*	50%	Deductible & 50% Coinsurance
Diabetic supplies, drugs & equipment *Diabetic drugs are covered at in-network benefit level.*	50%	
Infertility services – *prior authorization required* *Some restrictions may apply*	Applicable Copayment	Deductible & Coinsurance
Home health care *100 visit limit per member per calendar year*	OV Copayment	$50 Deductible & 20% Coinsurance

PREVENTIVE CARE SCHEDULES

Well Child Care *(including immunizations)*

- 7 exams, birth up to age 1
- 7 exams, ages 1 up to 5
- 1 exam every year, ages 5 up to 22

Adult Exams

- 1 exam every year, ages 22 +

Mammography

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

Vision Exams: 1 exam every 2 calendar years

Hearing Exams: 1 exam per calendar year

OB/GYN Exams: 1 exam per calendar year

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.
- 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.

* Copayment depends on if the 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 POS 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.

Non GF
Effective 1/1/12

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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:***
Tier 1	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
Tier 2	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
Tier 3	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:
Annual Maximum	Per member per calendar year	Unlimited

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.

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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 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.