Anthem

Employer/Group: REGIONAL SCHOOL DISTRICT #14
Firm Division: 085722008 - REGIONAL SCHOOL DISTRICT NO. 14-CAFETERIA

CENTURY PREFERRED,$20.00

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

COST SHARE PROVISIONS	In Network *Member Pays:*	Out-of-Network *Member Pays:*
Office Visit Copayment	$20.00	Deductible & Coinsurance
Specialist Visit Copayment	$20.00	
Hospital Copayment *(per admission)*	$25.00	
Urgent Care Copayment	$25.00	
Outpatient Surgery Copayment	$25.00	
Emergency Room Copayment *(waived if admitted)*	$25.00	$25.00
Annual Deductible *(indiviual/2-member family/3+ member family)*	Does not apply	$200/$400/$500
Coinsurance	Does not apply	20 %
Coinsurance Maximum *(indiviual/2-member family/3+ member family)*	Does not apply	$200/$400/$500
Lifetime Maximum	Unlimited	$1,000,000

PREVENTIVE CARE

Well child care*	No Copayment	Deductible & Coinsurance
Periodic, routine health examinations*	No Copayment	Deductible & Coinsurance
Routine eye exams	No Copayment	Deductible & Coinsurance
Routine OB/GYN visits	No Copayment	
Mammography*	No Copayment	
Hearing screening	$20.00	

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MEDICAL CARE	In Network *Member Pays:*	Out-of-Network *Member Pays:*
Office visits	$20.00	Deductible & Coinsurance
Office visits - Specialist	$20.00	
Outpatient mental health & substance abuse *(prior authorization may be required)*	Refer to Plan Document	
OB/GYN care	No Copayment	
Maternity care *(initial visit subject to copayment, no charge thereafter)*	$20.00	
Diagnostic lab and x-ray	Refer to Plan Document	
High-cost outpatient diagnostic *(prior authorization may be required)* *The following are subject to copay: MRI, MRA, CAT, CTA, PET, SPECT scans*	No Copayment	
Allergy services - Office Visits	$20.00	
Allergy services - Testing	$20.00	
Allergy services - Injections *(80 - Within 3 Years)*	No Copayment	

HOSPITAL CARE - *Prior authorization may be required*		
Semi-private room *(General/Medical/Surgical/Maternity)*	Refer to Hospital Copayment	Deductible & Coinsurance
Inpatient mental health and substance abuse	Refer to Plan Document	
Skilled nursing facility *(up to 120 days per calendar year)*	$25.00	
Rehabilitative services *(up to 60 days per calendar year)*	No Charge	
Outpatient surgery *(in a hospital or surgi-center)*	$25.00	

EMERGENCY CARE		
Walk-in centers	$20.00	Deductible & Coinsurance
Urgent care *(at participating centers only)*	$25.00	Deductible & Coinsurance
Emergency care *(copayment waived if admitted)*	$25.00	$25.00
Ambulance	No Copayment	No Copayment

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OTHER HEALTH CARE	In Network *Member Pays:*	Out-of-Network *Member Pays:*
Physical, Occupational, Speech and Chiropractic Therapies *(50 - Per Member Per Calendar Year)*	No Copayment	Deductible & Coinsurance
Durable Medical Equipment and Prosthetics *(Unlimited maximum per calendar year)*	No Copayment	Deductible & Coinsurance
Infertility Services *(Prior authorization may be required - Some restrictions may apply)*	Refer to Plan Document	Deductible & Coinsurance
Home Health Care	No Copayment	$50.00 Deductible & 20% Coinsurance

*** PREVENTIVE CARE SCHEDULES**

Well Child Care: *(including immunizations)*

0 TO 1 YR - 6 EXAMS TOTAL
1 YR- 5YRS - 6 EXAMS TOTAL
6 YR- 10YRS- 1 EXAM EVERY 2 YEARS
11YRS-21YRS- 1 EXAM EVERY YEAR

Adult Exams:

22YRS- 29YRS - 1 EXAM EVERY 5 YEARS
30YRS- 39YRS - 1 EXAM EVERY 3 YEARS
40YRS- 49YRS - 1 EXAM EVERY 2 YEARS
50YRS+ - 1 EXAM EVERY YEAR

Mammography: *(additional exams when medically necessary)*

AGE 35-39, 1 BASELINE EXAM;
AGE 40 AND OVER, 1 EVERY YEAR

Vision Exams: ONCE EVERY 2 YEARS
Hearing Exams: ONCE EVERY 2 YEARS
OB/GYN Exams: 1 EXAM PER MEMBER PER CALENDAR YEAR

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Note To Benefit Descriptions:

- In situations where the member is responsible for obtaining the necessary prior authorizations 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.
- Skilled Nursing Facility Copay is waived if admitted within 3 days of hospital discharge.
- Home Health Care services are covered when in lieu of hospitalization. Includes infusion (IV) therapy.
- 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. Covered services are subject to a lifetime maximum of $1,000,000.

Please refer to the *SpecialOffers@Anthem* brochure in your enrollment kit for information on the discounts we offer 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 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.

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

January 7, 2009

Anthem

Employer/Group: REGIONAL SCHOOL DISTRICT #14
Firm Division: 085722008 - REGIONAL SCHOOL DISTRICT NO. 14-CAFETERIA
CENTURY PREFERRED 3-TIER MANAGED PRESCRIPTION DRUG PROGRAM
$10 Copayment Generic Drugs
$20 Copayment Listed Brand-Name Drugs
$30 Copayment Non-Listed 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: Listed Brand-Name Drugs	The term "listed brand-name" refers to a brand-name prescription drug identified on the formulary by Anthem Blue Cross and Blue Shield. Tier 2 copayment applies.	$20
Tier 3: Non-Listed Brand-Name Drugs	The term "non-listed brand-name" refers to a brand-name prescription drug not identified on the formulary by Anthem Blue Cross and Blue Shield. Tier 3 copayment applies.	$30

		Plan Pays:
Annual Maximum	Per member per calendar year	Unlimited

F to use the 3-Tier Managed Prescription Drug Program

The 3-Tier Managed Prescription Drug Program incorporates different levels of copayments for three types of prescription drugs: generic, listed brand-name and non-listed brand-name, 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 listed drugs have lower member copayments than non-listed drugs (but may not have a lower overall cost in all instances.) You minimize your copayments when you use generic prescriptions and listed brand-name prescriptions. You will still have coverage for non-listed brand-name drugs, but at a higher cost share. **Talk to your provider** about using generic drugs or listed 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 will be responsible for **two** copayments when purchasing a **31-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 a generic drug is available and you request the equivalent brand-name drug, you will be responsible for the applicable copayment *plus* the difference in cost between the generic and brand-name drug.
- If your physician determines that the brand equivalent is medically necessary and indicates on the prescription 'Dispense as written', you will only be responsible for the applicable copay.

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 Rx, the voluntary mail-service drug program for members who regularly take one or more types of mainten drugs. Members can order up to a **100-day supply** of these medications and have them delivered directly to their home.

The $10 generic/$20 listed brand-name/$30 non-listed brand-name copayment and Unlimited annual maximum apply. When ordering a **31-day to 100 day supply, two copayments** will apply, as follows: $20 generic/$40 listed brand-name/$60 non-listed brand.

National Pharmacy Network

Members also have access to a network of more than 53,000 retail pharmacies throughout the country. Members may call 1-888-207-4214, or go to www.anthemprescription.com, to locate a participating pharmacy when traveling outside the state.

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 Dc 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 **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 listed brand-name/$30 non-listed brand-name 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.

January 7, 2009