



**Employer/Group:** TOWN OF MADISON

**Firm Division:** 000939600 - TOWN OF MADISON POLICE ACTIVE HMO / LOCAL 456

**BLUECARE POS,\$20.00/\$30.00**

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.

<b>COST SHARE PROVISIONS</b>	<b>In Network Member Pays:</b>	<b>Out-of-Network Member Pays:</b>
Office Visit Copayment	\$20.00	Deductible & Coinsurance
Specialist Visit Copayment	\$30.00	
Hospital Copayment( <i>per day/per stay/per year</i> )	\$500/	
Urgent Care Copayment	\$50.00	
Outpatient Surgery Copayment	\$100.00	
Ambulatory Surgery Copayment	\$100.00	
Emergency Room Copayment ( <i>waived if admitted</i> )	\$100.00	\$100.00
Annual Deductible ( <i>individual/2-member family/3+ member family</i> )	Does not apply	\$500/ /\$1,500
Coinsurance	Does not apply	30 %
Coinsurance Maximum ( <i>individual/2-member family/3+ member family</i> )	Does not apply	\$2,500/ /\$7,500
Lifetime Maximum	Unlimited	Unlimited

#### PREVENTIVE CARE

Well child care*	No Copayment	Not covered
Periodic, routine health examinations*	No Copayment	Not covered
Routine eye exams	No Copayment	Deductible & Coinsurance
Routine OB/GYN visits	No Copayment	
Mammography*	No Copayment	
Hearing screening	No Copayment	



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<b>MEDICAL CARE</b>	<b>In Network Member Pays:</b>	<b>Out-of-Network Member Pays:</b>
Office visits - PCP	\$20.00	Deductible & Coinsurance
Office visits - Specialist	\$30.00	
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		
Allergy services - Office Visits	\$30.00	
Allergy services - Testing	\$30.00	
Allergy services - Injections (60 - Within 2 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)	No Copayment	
Rehabilitative services (up to 60 days per calendar year)	No Charge	
Outpatient surgery (in a hospital)	\$100.00	
Ambulatory surgery (in other than a hospital setting)	\$100.00	

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<b>EMERGENCY CARE</b>	<b>In Network Member Pays:</b>	<b>Out-of-Network Member Pays:</b>
Walk-in centers	\$20.00	Deductible & Coinsurance
Urgent care <i>(at participating centers only)</i>	\$50.00	Deductible & Coinsurance
Emergency care <i>(copayment waived if admitted)</i>	\$100.00	\$100.00
Ambulance	No Copayment	No Copayment

**OTHER HEALTH CARE**

Physical, Occupational, Speech and Chiropractic Therapies <i>(No Limit)</i>	No Copayment	Deductible & Coinsurance
Durable Medical Equipment and Prosthetics <i>(Unlimited maximum per calendar year)</i>	20%	Deductible & Coinsurance
Infertility Services <i>(Prior authorization may be required - Some restrictions may apply)</i>	Refer to Plan Document	Deductible & Coinsurance
Home Health Care	OV Copayment	No Copayment

**\* PREVENTIVE CARE SCHEDULES**

<i>Well Child Care: (including immunizations)</i>
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<i>Adult Exams:</i>
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**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:** 1 EXAM PER MEMBER PER CALENDAR YEAR  
**OB/GYN Exams:** DOES NOT APPLY

**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.
- 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.
- Members are responsible for the balance of charges billed by out-of-network providers after payment for covered services has been made by Anthem Blue Cross and Blue Shield according to the Comprehensive Schedule of Professional Services.

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.

September 9, 2013



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**BLUECARE 3-TIER PRESCRIPTION DRUG PROGRAM**

**\$10 Copayment Generic Drugs**

**\$25 Copayment Listed Brand-Name Drugs**

**\$40 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.	\$25
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.	\$40
		<b>Plan Pays:</b>
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: 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 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 generic drug at a participating pharmacy, you will only be responsible for a Tier 1 copayment.
- When a generic equivalent is available and you obtain a listed or non-listed brand-name drug, you will be responsible for the applicable Tier copayment *plus* the difference in cost between the generic and listed or non-listed 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 Rx, 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 generic/\$25 listed brand-name/\$40 non-listed brand-name copayment and Unlimited annual maximum apply. When ordering a **31-day to 90 day supply**, two copayments will apply, as follows: \$20 generic/\$50 listed brand-name/\$80 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](http://www.anthemprescription.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 generic/\$25 listed brand-name/\$40 non-listed brand-name 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.*

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