Your 2011 LPPO Prescription Drug Benefit Chart Premier 10/20/40

| BOLINIA A | , |
|--|---|
| Deductible | \$0 |
| Covered Services | What you pay |
| Initial Coverage | |
| Below is your payment responsibility until the cost paid | d by you for your prescriptions reaches your True Out |
| of Pocket costs of \$4,550. | |
| Retail Pharmacy | per 30-day supply |
| | (Specialty limited to a 30 day supply) |
| Generics, including Specialty Drugs | \$10 copay |
| | |

Preferred Brands, including Specialty Drugs and
Vaccines

Non-Preferred Brands and Non-Formulary Drugs

\$40 copay

Non-Preferred Brands and Non-Formulary Drugs \$40 copay

Typically retail pharmacies dispense a 30-day supply of medication. Some of our retail pharmacies can dispense up to a 90-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day

supply, you will need to pay two 30-day copays.

| Mail Order Pharmacy | per 90-day supply (Specialty limited to a 30 day supply; 30 day Retail copay applies) |
|--|---|
| Generics, including Specialty Drugs Select Generics | \$15 copay \$0 copay for Select Generics |
| Preferred Brands, including Specialty Drugs and Vaccines | \$50 copay |
| Non-Preferred Brands and Non Formulary Drugs | \$100 copay |

If you purchase drugs at Retail or Mail Order Pharmacies that are not listed in our participating pharmacy directory, you will be responsible for all amounts over our negotiated cost. If you need an emergency supply of drugs and you are not near a Retail Pharmacy in our participating pharmacy directory, you will not be responsible for amounts over our negotiated costs.

Vaccine Coverage

The up front costs for vaccines will vary based upon where the vaccine is purchased and administered. Some vaccines, such as Flu Vaccines, are paid under your Medicare Part B coverage. Vaccines that are covered by Medicare Part B are not covered by your Part D plan. Please see your Evidence of Coverage booklet for a complete explanation of your vaccine coverage.

A health plan with a Medicare contract.

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2011 STD Premier 10/20/40

P3TARO (10R)

07/08/2010

Premier 3 Tier - Open

| Covered Services | What you pay |
|---|---|
| Catastrophic Coverage | |
| Your payment responsibility changes after the cost you have Out of Pocket cost of \$4,550. | ve paid for prescription drugs reaches your True |
| Generics, including Specialty Drugs | \$2.50 copay or 5% coinsurance, whichever is greater (Specialty limited to 30 day supply) |
| Select Generics | \$0 copay for Select Generics |
| Preferred and Non-Preferred Brands including Specialty Drugs, Vaccines, and Non-Formulary Drugs | \$6.30 copay or 5% coinsurance, whichever is greater |
| Extra Covered Drug Group | (Specialty limited to 30 day supply) |
| These are drugs that are covered by your plan that are often. These drugs do not count towards your True Out of Pocket Catastrophic copays. | excluded from Part D Prescription Drug Plans. expenses. They do not qualify for lower |
| Benzodiazepines and Barbiturates Cosmetics Cough and Cold DESI Over the Counter Vitamins and Minerals | See Formulary for complete list of drugs covered |
| Erectile Dysfunction | |
| Generics | You pay your retail or mail order generic copa |
| • Brands | You pay your retail or mail order brand copay |

• Beginning in 2011, when the cost of Part D qualified drugs paid by you and this plan is more than \$2840, you will receive help paying your share of the cost of most covered brand drugs from Drug Manufacturers. This help will continue until the cost of Part D qualified drugs paid by you and the Drug Manufacturer Discount reaches the True Out of Pocket amount shown on this Benefit Chart. Drug Manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. Your plan covers some brand drugs beyond those covered by Medicare. The discount will not apply to benefits described in the "Extra Covered Drugs" section of this Benefit Chart.

Anthem Medicare Preferred (PPO) Prescription Drug Exclusions and Limitations

In addition to any exclusions or limitations described in the benefit chart, or anywhere else in this booklet, the following items and services are not covered by the plan, unless the plan covers them as "Extra Covered Drug Groups". Please see the "Extra Covered Drug Groups" section of the benefit chart in this booklet to find out which of the drugs listed below are covered under your plan.

- 1. Non-prescription drugs (or over-the-counter drugs)
- 2. Drugs when used to promote fertility
- 3. Drugs when used for the symptomatic relief of cough or colds
- 4. Drugs when used for treatment of anorexia, weight loss, or weight gain
- 5. Drugs when used for cosmetic purposes or to promote hair growth
- 6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- 8. Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction
- 9. Barbiturates and Benzodiazepines

Assistance for those who need help paying for prescriptions

If you have concerns about being able to afford the cost of your coverage, you may qualify for assistance. This assistance includes help with paying for your monthly premium as well as any required out-of-pocket costs you would typically pay as required by your benefits coverage, such as a copayment. Our customer service staff can help you determine if this additional layer of support is available to you. You can also call 1-800 MEDICARE (1-800-663-4227). TTY/TDD users should call 1-877-486-2048. Representatives from Medicare are available to help you 24 hours a day, 7 days a week. Or you can contact the Social Security Administration at 1-800-772-1213 between the hours of 7 a.m. to 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or your local State Medicaid office.

Retail plan pharmacies for short-term prescriptions

Retail plan pharmacies will fill your prescription for up to a 30-day supply of medication. For added convenience, some retail plan pharmacies will fill prescriptions for the mail order quantity listed in your benefit chart.

Mail order pharmacy services for maintenance medications

For prescriptions that you take on an ongoing basis, we offer the convenience of ordering through our preferred mail order pharmacy. You will get the most from your prescription drug benefits when you use our mail order pharmacy. You may order through the mail or by phone.

Using your pharmacy benefits is as easy as

1-2-3

- Use participating retail
 plan pharmacies for
 short-term prescriptions
- Sign up for mail order pharmacy services for prescriptions you'll need longer term
- Members can order their long-term prescription refills by phone or through the mail.