

Your Anthem Benefits



State of Indiana Benefits Comparison Summary of Benefits for 2010

	CONSUMER-DRIVEN HEALTH PLAN 1	CONSUMER-DRIVEN HEALTH PLAN 2	TRADITIONAL PPO
Deductible (Single/Family) Deductibles are co-mingled Network and Non-network for Consumer-Driven Health Plans <u>ONLY</u>	\$ 2,500 single Network/Non-network \$ 5,000 family Network/Non-network The Family deductible must be satisfied by either one Enrollee or all Enrollees collectively before any Covered Services are paid by the Plan. The Single deductible does not apply to a family plan.	\$ 1,500 single Network/Non-network \$ 3,000 family Network/Non-network The Family deductible must be satisfied by either one Enrollee or all Enrollees collectively before any Covered Services are paid by the Plan. The Single deductible does not apply to a family plan.	Network/Non-Network \$500 single/\$1000 single \$1000 family/\$2000 family The Family deductible must be satisfied by either one Enrollee or all Enrollees collectively before any Covered Services are paid by the Plan. The Single deductible does not apply to a family plan.
Out of Pocket Maximum (Single/Family) Out of pockets are co-mingled Network and Non-network for Consumer-Driven Health Plans <u>ONLY</u>	\$4,000 single coverage \$8,000 family coverage The Family out-of-pocket limit must be satisfied by either one Enrollee or all Enrollees collectively before it applies under the Plan. The Single out-of-pocket limit does not apply to a family plan. Includes the deductible	\$3,000 single coverage \$6,000 family coverage The Family out-of-pocket limit must be satisfied by either one Enrollee or all Enrollees collectively before it applies under the Plan. The Single out-of-pocket limit does not apply to a family plan. Includes the deductible	Network/Non-Network \$2000 single/\$4000 single \$4000 family/\$8000 family The Family out-of-pocket limit must be satisfied by either one Enrollee or all Enrollees collectively before it applies under the Plan. The Single out-of-pocket limit does not apply to a family plan. Includes the deductible
	Note: The out of pocket maximum limit includes all Deductibles and/or Coinsurance you incur in a Benefit Period. After you or the Family collectively have met the out-of-pocket limit, the plan will begin paying 100% of covered charges for the remainder of that calendar year except for non-network Human Organ Tissue Transplant services.	Note: The out of pocket maximum limit includes all Deductibles and/or Coinsurance you incur in a Benefit Period. After you or the Family collectively have met the out-of-pocket limit, the plan will begin paying 100% of covered charges for the remainder of that calendar year except for non-network Human Organ Tissue Transplant services.	Note: The out of pocket maximum limit includes all Deductibles and/or Coinsurance you incur in a Benefit Period. After you or the Family collectively have met the out-of-pocket limit, the plan will begin paying 100% of covered charges for the remainder of that calendar year except for non-network Human Organ Tissue Transplant services.

Insurance Companies, Inc.
Association

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Professional Office Services Including allergy <ul style="list-style-type: none"> - testing and treatment - serum and injections 	20% Network/40% Non-network per visit	20% Network/40% Non-network per visit	20% Network/40% Non-network per visit
Preventive Care Services Services include but are not limited to: Annual Physical Exams, Pelvic Exams, Pap testing, PSA tests, immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams <ul style="list-style-type: none"> • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility • Routine Mammograms • Screening Colorectal Cancer Exam/Laboratory Testing All preventive services are limited to one of each service per year per covered member	Covered In Full Network/40% Non-network Both In-Network and Out-of Network <u>Not</u> subject to deductible	Covered In Full Network/40% Non-network Both In-Network and Out-of Network <u>Not</u> subject to deductible	Covered In Full Network/40% Non-network Both In-Network and Out-of Network <u>Not</u> subject to deductible
Medical Supplies, Equipment & Appliances	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Maternity Services	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Inpatient Facility Services	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Outpatient Facility Services	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Professional Inpatient/Outpatient Services	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Emergency and Urgent Care: <ul style="list-style-type: none"> • Emergency Care in ER Room • Urgent Care Facility 	20% Network/20% Non-network	20% Network/20% Non-network	20% Network/20% Non-network
Ambulance	20% Network/20% Non-network	20% Network/20% Non-network	20% Network/20% Non-network
Outpatient Therapy Services (Combined Network and Non-network limits apply) Limits apply to: <ul style="list-style-type: none"> • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits 	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network

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Diabetes Self Management Training	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Diagnostic Services (i.e. lab, x-ray, MRI)	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Temporomandibular Joint (TMJ) Services <ul style="list-style-type: none"> • Outpatient Facility • Provider Individual • TMJ Surgery - Professional Services 	20% Network/40% Non-network 20% Network/40% Non-network 20% Network/40% Non-network \$2,500 lifetime maximum for all services (Network/Non-network)	20% Network/40% Non-network 20% Network/40% Non-network 20% Network/40% Non-network \$2,500 lifetime maximum for all services (Network/Non-network)	20% Network/40% Non-network 20% Network/40% Non-network 20% Network/40% Non-network \$2,500 lifetime maximum for all services (Network/Non-network)
Hospice	20% Network/20% Non-network	20% Network/20% Non-network	20% Network/20% Non-network
Home Health Care No RN/LPN unless billed through a Home Health Care Agency	20% Network/40% Non-network Private Duty Nursing limited to \$5,000 plan maximum per enrollee	20% Network/40% Non-network Private Duty Nursing limited to \$5,000 plan maximum per enrollee	20% Network/40% Non-network Private Duty Nursing limited to \$5,000 plan maximum per enrollee
Home IV Therapy	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network

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Managed Mental Health including Substance Abuse	20% Network/40% Non-network Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.	20% Network/40% Non-network Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.	20% Network/40% Non-network Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.
Human Organ and Tissue Transplants (HOTT) Specialty Network	20% Network/40% Non-network See contract for other maximums and exclusions	20% Network/40% Non-network See contract for other maximums and exclusions	20% Network/40% Non-network See contract for other maximums and exclusions
Lifetime Maximum includes Human Organ and Tissue Transplants (HOTT)	\$2 million Network and Non-network combined	\$2 million Network and Non-network combined	\$2 million Network and Non-network combined
Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY MEDCO¹			
Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum			
	Retail Rx (Up to a 30 Day Supply)	Mail Order Rx (Up to a 90 Day Supply)	
Generic	\$10 co-pay	\$20 co-pay	
Formulary	20% - minimum \$30, maximum \$50	20% - minimum \$60, maximum \$100	
Brand Non-Formulary	40% - minimum \$50, maximum \$70	40% - minimum \$100, maximum \$140	
Specialty	40% - minimum \$75, maximum \$150 (30-day supply only)		

See Benefit Booklet for exclusions

Notes:

- ¹Prescription benefits are being administered by Medco. Any questions related to prescription coverage should be directed to (877)841-5241.
- Non-network human organ and tissue transplants are excluded from the out-of-pocket limits
- Dependent age: to the end of calendar year of the child's 19th birthday; or to the end of the calendar year of the child's 23rd birthday if the Dependent qualifies as a Full Time Student.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- Benefit period = calendar year
- Prosthetic limbs are unlimited and do not apply to the plan lifetime maximum.
- We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.
- Kidney and Cornea transplant services are treated the same as any other illness and subject to the medical benefits.

Precertification:

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.