

Your Anthem Benefits



State of Indiana - Consumer Driven Health Plan 1 Blue AccessSM for Health Savings Accounts Summary of Benefits, Effective January 1, 2010

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage. (Deductibles are co-mingled Network and Non-network)		Single: \$2,500 Family: \$5,000
Out-of-Pocket Limit (Single/Family) Family coverage requires the family OOP to be met before 100% coverage applies. The single OOP does not apply to family coverage. Out of Pockets are co-mingled network and non-network Includes the deductible		Single: \$4,000 Family: \$8,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum: <ul style="list-style-type: none"> allergy injections (PCP and SCP) and allergy testing non-routine mammograms diabetic education (regardless of outpatient setting) certain medical nutritional therapy MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds 	20%/20% 20% 20% 20% 20% 20%	40% 40% 40% 40% 40%
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	No deductible/coinsurance No deductible/coinsurance No deductible/coinsurance No deductible/coinsurance	40% (not subject to deductible) 40% not subject to deductible) 40% (not subject to deductible) 40% (not subject to deductible)
Emergency and Urgent Care <ul style="list-style-type: none"> Emergency Room Services @ Hospital (facility/other covered services) Urgent Care Center Services 	20% 20%	20% 20%
Maternity Services	20%	40%
Inpatient and Outpatient Professional Services Include but are not limited to: <ul style="list-style-type: none"> Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams 	20%	40%
Inpatient Facility Services	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	20%	40%

Covered Benefits	Network	Non-Network
Other Outpatient Services <i>(including but not limited to):</i> <ul style="list-style-type: none"> Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. Home Care Services (Network/Non-Network combined) Unlimited visits (includes IV Therapy) (\$5,000 Private Duty Nursing LTM applies) (No RN/LPN unless billed through a Home Health Care Agency) Durable Medical Equipment and Orthotics (Network/Non-network combined) Unlimited benefit maximum (including Medical Supplies) Prosthetic Devices Unlimited benefit maximum for Prosthetics received on an out-patient basis. Surgical Prosthetics do not apply) Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services 	20% 20% 20%	40% 20% 20%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility <ul style="list-style-type: none"> Physical therapy: 25 visits Occupational therapy: 25 visits Manipulation therapy: 12 visits Speech therapy: 25 visits 	20% 20%	40% 40%
Behavioral Health Services: Mental Health and Substance Abuse¹ <ul style="list-style-type: none"> Inpatient Facility Services (Residential M/N covered as Inpatient) Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.	20% 20%/20% 20%	40% 40% 40%
Human Organ and Tissue Transplants² <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage 	20%	40%
Lifetime Maximum (Combined Network and Non-Network) Medical (Includes Human Organ and Tissue Transplants) Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	\$2 million Unlimited	\$2 million Unlimited
Prescription Drug Options: Network Tier structure equals 1/2/3 (and 4, if applicable) <ul style="list-style-type: none"> Network Retail Pharmacies: (30-day supply) Includes diabetic test strip Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip Anthem Rx Specialty: (30-day supply) 	Tier 1 - \$10 Tier 2 – 20%, \$30 min/\$50 max Tier 3 – 40%, \$50 min/\$70 max Tier 1 - \$20 Tier 2 – 20%, \$60 min/\$100 max Tier 3 – 40%, \$100 min/\$140 max 40%, \$75 min/\$150 max	40% Not covered Not covered

Notes:

- Non-network Human Organ and Tissue Transplants are excluded from the Out-of-pocket limits.
- Dependent age: to the end of calendar year in which the child attains age 24.
- 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.
- Prosthetic limbs are unlimited and do not apply to the plan lifetime maximum.

¹We 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.

²Kidney and Cornea 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.