Your Anthem Benefits

Anthem

State of Indiana - Traditional PPO
Blue Access℠ (PPO)
Summary of Benefits, Effective January 1, 2010

Covered Benefits	Network	Non-Network
Deductible (Single/Family) *Family coverage requires the family deductible to be met before coinsurance applies.* *The single deductible **does not** apply to family coverage.*	$500/$1,000	$1,000/$2,000
Out-of-Pocket Maximum (Single/Family) *Family coverage requires the family OOP to be met before 100% coverage applies.* *The single OOP **does not** apply to family coverage.*	$2,000/$4,000	$4,000/$8,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum: • 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% 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 • 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 • **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: • 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 • Surgery and administration of general anesthesia	20%	40%

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Covered Benefits	Network	Non-Network
Other Outpatient Services *(including but not limited to):* • 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	20%	40%
• Hospice Care	20%	20%
• Ambulance Services	20%	20%
Outpatient Therapy Services (Combined Network and Non-Network limits apply)		
• Physician Home and Office Visits (PCP/SCP)	20%/20%	40%
• Other Outpatient Services @ Hospital/Alternative Care Facility	20%	40%
• Physical therapy: 25 visits		
• Occupational therapy: 25 visits		
• Manipulation therapy: 12 visits		
• Speech therapy: 25 visits		
Behavioral Health Services:		
Mental Health and Substance Abuse[1]		
• Inpatient Facility Services (Residental M/N covered as Inpatient)	20%	40%
• Physician Home and Office Visits (PCP/SCP)	20%/20%	40%
• Other Outpatient Services @ Hospital/Alternative Care Facility	20%	40%
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[2] • Acquisition and transplant procedures, harvest and storage	20%	40%
Lifetime Maximum (Combined Network and Non-Network)		
Medical (Includes Human Organ and Tissue Transplants)	$2 million	$2 million
Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	Unlimited	Unlimited

Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY MEDCO[3]

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)	

Notes:

- *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.*
- *Prosthetic limbs are unlimited and do not apply to the plan lifetime maximum.*

[1] *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.*

[2] *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*

[3] *PRESCRIPTION BENEFITS ADMINISTERED BY MEDCO. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO* ***(877)841-5241***

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.