



BENEFIT SUMMARY

~ January 1, 2010 - December 31, 2010 ~

*** State of Indiana ***

The Benefit Summary indicates WHP benefits, Member Copays, Coinsurance and Deductibles. The entire provisions of benefits and exclusions are contained in the Employer and Member Agreement. In the event of a conflict between the Agreement and this summary description, the terms of the Agreement will prevail.

CUSTOMER SERVICES DEPARTMENT

(812) 426-6600 ♦ (800) 521-0265

GENERAL BENEFIT LIMITS

Benefit Limit Per Lifetime (Excluding Organ & Tissue Transplants) (limited to \$1,000,000 per contract year)	\$5,000,000
Deductible Per Calendar Year.....	None/person, None/family
Out-of-Pocket Maximum Per Calendar Year	\$2,000/person, \$4,000/family
♦ Copays do not apply toward the Deductible or Out-of-Pocket Maximum	
♦ Deductible applies to the Out-of-Pocket Maximum	

PHYSICIAN OFFICE VISITS

Primary Care Physician Office Visits (Professional Services Fee).....	100% Coverage after \$20 Copay per visit
Visits to Specialist upon referral (Professional Services Fee).....	100% Coverage after \$20 Copay per visit
Chiropractic (limited to \$750 per contract year)	100% Coverage after \$20 Copay per visit

PHYSICIAN OFFICE OTHER SERVICES

Including, but not limited to: Immunizations and injections; allergy tests and treatment; hearing exams; laboratory, X-ray & other diagnostic services; care of immediate medical need; mammogram, PSA and colorectal exams & testing	100% Coverage
Selected Benign Lesion Removal.....	50% Coverage after \$20 Copay

PHYSICIAN HOSPITAL SERVICES

Physician Services for Surgery, Visits and Examinations.....	100% Coverage
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INPATIENTS HOSPITAL SERVICES

Semi-Private Room and Board.....	100% Coverage after \$500 Copay per Admission
Services include: Private room if medically necessary, Operating, recovery rooms and other special units including intensive care	
Maternity care, Hospital ancillary services including laboratory, x-ray, EKG and other diagnostic services.	
Other services including anesthesia, physical therapy and medication, Administration of blood and blood plasma	
Non-experimental organ transplants when prior authorized	

OUTPATIENT SERVICES

Outpatient Surgery.....	100% Coverage after \$250 Copay per Surgery
Outpatient services including laboratory, x-ray, EKG and other diagnostic services....	100% Coverage
Other outpatient services for MRI, CT, PET and SPECT.....	100% Coverage after \$50 Copay
Selected Benign Lesion Removal.....	50% Coverage after \$20 Copay
Emergency room services for life-threatening medical emergencies.....	100% Coverage after \$75 Copay per visit [waived if admitted to hospital as an inpatient]
Immediate/Urgent Care Center visit.....	100% Coverage after \$35 Copay per visit
Alcohol & Drug Addiction.....	100% Coverage after \$20 Copay per visit
Hearing Tests.....	100% Coverage after \$20 Copay per visit
Allergy Testing.....	100% Coverage after \$20 Copay per visit
<i>Only prepackaged allergy medicines requiring a prescription will be covered under prescription drug section. Serums are not covered under the prescription drug section.</i>	

MENTAL HEALTH SERVICES

Inpatient Mental Health Services for Evaluation.....	100% Coverage after \$500 Copay per Admission
Outpatient Visits for Psychotherapy, Crisis Intervention or Psychiatric Testing.....	100% Coverage after \$20 Copay
Psychiatric Intensive Outpatient Program (Ambulatory Level Two Mental Health Programs)	100% Coverage after \$20 Copay

SUBSTANCE ABUSE SERVICES

Inpatient Substance Abuse Services for Diagnosis and Detoxification.....	100% Coverage after \$500 Copay per Admission
Outpatient Visits for Evaluation or Crisis Intervention.....	100% Coverage after \$20 Copay

OTHER SERVICES

Dialysis.....	100% Coverage after \$20 Copay
Durable Medical Equipment.....	80% Coverage
Emergency Ambulance.....	100% Coverage after \$50 Copay per Transport
Family Planning including Infertility, Counseling, Testing to Diagnosis, Surgical Treatment and Sterilizations.....	80% Coverage
Home Health Care in Lieu of Hospitalization.....	100% Coverage after \$20 Copay per day
Hospice Care.....	100% Coverage
Morbid Obesity Surgery.....	80% Coverage plus applicable inpatient or outpatient Copay
Prosthetic Devices and Corrective Appliances.....	80% Coverage
Physical, Occupational and Speech Therapy.....	100% Coverage after \$20 Copay per visit
Temporomandibular Joint Dysfunction or Disease (TMJ) when medically necessary and prior authorized.....	Applicable office visit, inpatient or outpatient Copay

PRESCRIPTION DRUGS

Prescription drugs for up to 30-day supply. OTC Select, Generic and Select Prescription Drugs are available through the participating mail order pharmacy for two thirty (30) day supply copayments for a 90-day supply. Non -Select is available for three thirty (30) day supply copayments for a 90-day supply. To be covered, certain prescription drugs may require Prior Authorization.

OTC Select Drugs.....	\$5 Copay
Generic Prescription Drugs.....	\$10 Copay
Formulary Brand Name Drugs and Formulary Diabetic Supplies.....	\$20 Copay
Brand Name or Generic Non-Formulary Drugs.....	60% Coverage (\$40 minimum, \$100 maximum)
Biopharmaceutical Drugs/Injectable Drugs.....	80% Coverage
Diaphragms, Cervical Caps.....	80% Coverage