

# Your Anthem Benefits



State of Indiana Benefits Comparison

Summary of Benefits for 2014

Please note: As we receive additional guidance and clarification on federal health care reform from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

	CONSUMER-DRIVEN HEALTH PLAN 1	CONSUMER-DRIVEN HEALTH PLAN 2	TRADITIONAL PPO
<b>Deductible (Single/Family)</b>  <b>Deductibles are combined network and non-network for Consumer-Driven Health Plans <u>ONLY</u></b>	\$ 2,500 single network/non-network \$ 5,000 family network/non-network	\$ 1,500 single network/non-network \$ 3,000 family network/non-network	<b>Network/Non-Network</b> \$750 single/\$1,500 single \$1,500 family/\$3,000 family
	When applicable, 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.		
<b>Out-of-Pocket Maximum (Single/Family)</b>  <b>Out-of-pockets are combined network and non-network for Consumer-Driven Health Plans <u>ONLY</u></b>	\$4,000 single coverage \$8,000 family coverage	\$3,000 single coverage \$6,000 family coverage	<b>Network/Non-Network</b> \$2,500 single/\$5,000 single \$5,000 family/\$10,000 family
	When applicable, 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.		
	<b>Note:</b> 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.		

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	CONSUMER-DRIVEN HEALTH PLAN 1	CONSUMER-DRIVEN HEALTH PLAN 2	TRADITIONAL PPO
<b>Professional Office Services</b> <b>Including allergy</b> <ul style="list-style-type: none"> <li>- testing and treatment</li> <li>- serum and injections</li> </ul>	20% Network/40% Non-network per visit	20% Network/40% Non-network per visit	30% Network/50% Non-network per visit
<b>Preventive Care Services</b> 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"> <li>• Physician home and office visits (PCP/SCP)</li> <li>• Other outpatient services @ hospital/alternative care facility</li> <li>• Routine mammograms</li> <li>• Screening colorectal cancer exam/laboratory testing</li> </ul> <b>All preventive services are limited to one of each service per year per covered member</b> <b>If the office visit is billed separately or if the primary purpose of the office visit is not for the delivery of a preventive service, cost sharing may be imposed for the office visit</b>	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/50% Non-network  Both In-Network and Out-of Network <u>not</u> subject to deductible
<b>Medical Supplies, Equipment &amp; Appliances</b>	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
<b>Maternity Services</b>	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
<b>Inpatient Facility Services</b>	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
<b>Outpatient Facility Services</b>	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
<b>Professional Inpatient/Outpatient Services</b>	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
<b>Emergency (ER) and Urgent Care:</b> <ul style="list-style-type: none"> <li>• Emergency Care in ER</li> <li>• Urgent Care Facility</li> </ul>	20% Network/20% Non-network 20% Network/20% Non-network	20% Network/20% Non-network 20% Network/20% Non-network	30% Network/30% Non-network 30% Network/30% Non-network
<b>Ambulance</b>	20% Network/20% Non-network	20% Network/20% Non-network	30% Network/30% Non-network
<b>Outpatient Therapy Services (Combined Network and Non-network limits apply)</b> Limits apply to: <ul style="list-style-type: none"> <li>• Physical therapy: 25 visits</li> <li>• Occupational therapy: 25 visits</li> <li>• Manipulation therapy: 12 visits</li> <li>• Speech therapy: 25 visits</li> </ul>	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network

	CONSUMER-DRIVEN HEALTH PLAN 1	CONSUMER-DRIVEN HEALTH PLAN 2	TRADITIONAL PPO
<b>Diabetes Self Management Training</b>	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
<b>Diagnostic Services</b> (i.e. lab, x-ray, MRI)	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
<b>Temporomandibular Joint (TMJ) Services</b> <ul style="list-style-type: none"> <li>• Outpatient facility</li> <li>• Provider individual</li> <li>• TMJ surgery - professional services</li> <li>• Private Duty Nursing limited to 82 visits/Calendar Year and 164 visits/lifetime.</li> </ul>	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
<b>Hospice</b>	20% Network/20% Non-network	20% Network/20% Non-network	30% Network/30% Non-network
<b>Home Health Care</b> No RN/LPN unless billed through a home health care agency	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
<b>Home IV Therapy</b>	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
<b>Managed Mental Health including Substance Abuse</b> Authorization of all inpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed.	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
<b>Human Organ and Tissue Transplants (HOTT) Specialty Network</b> See contract for other maximums and exclusions	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
<b>Prescription Drug Coverage (applies to all 3 plans) – THIS COVERAGE IS ADMINISTERED BY EXPRESS SCRIPTS<sup>1</sup></b> Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum			
	<b>Retail Rx (Up to a 30-day supply)</b>	<b>Mail Order Rx (Up to a 90-day supply)</b>	
<b>Generic</b>	\$10 co-pay	\$20 co-pay	
<b>Formulary</b>	20% - minimum \$30, maximum \$50	20% - minimum \$60, maximum \$100	
<b>Brand Non-Formulary</b>	40% - minimum \$50, maximum \$70	40% - minimum \$100, maximum \$140	
<b>Specialty</b>	40% - minimum \$75, maximum \$150 (30-day supply only)		

**See Benefit Booklet for exclusions**

**Notes:**

- <sup>1</sup>Prescription benefits are being administered by Express Scripts. 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 child's 26<sup>th</sup> birthday
- 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
- 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.
- Private Duty Nursing – limited to limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Skilled Nursing Facility – limited to 100 days.

**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.