2011 BLUE RETIREE COMPARISON CHART FOR
STATE OF INDIANA – BLUE RETIREE PLAN 2

Covered Services	Medicare Pays*	Blue Retiree Plan Pays*
Part A Covered Services		
Inpatient Hospitalization		
First 60 days	Pays all but Part A deductible.	Pays the Medicare Part A deductible.
61st to 90th day	Pays all but the daily copayment.	Pays the daily copayment
60 day lifetime reserve	Pays all but the daily copayment.	Pays the daily copayment
Continuous inpatient care after lifetime reserve has been exhausted	Pays nothing	Covered under Compliment [90% or Covered in Full] up to an additional 365 days. Beyond 365 days, covered under Major Medical.
Skilled Nursing Facility		
First 20 days of skilled care	Pays all covered charges.	No benefit. Paid in full by Medicare.
21st to 100th day of continued skilled care	Pays all but the daily copayment.	Pays the daily copayment
Additional days of continued care	Pays nothing	Covered under Major Medical.
Home Health		
Non-custodial medical and nursing care	Pays 100% of approved charges.	No benefit. Paid in full by Medicare.
Hospice Care	Pays 100% of approved charges.	No benefit. Paid in full by Medicare.
Blood	Pays for all but the first 3 pints.	Pays for the first 3 pints.
Part B Covered Services		
Medical/Surgical Treatment and Doctors' care (includes doctors, hospital, office services including surgery, office calls, and hospital visits)	Pays 80% of the allowed amount after a $162 deductible.	Pays the annual $162 deductible and the remaining 20% of Medicare's allowed charges.
Outpatient Services (includes diagnostic services, physical therapy, x-rays, and laboratory tests)	Pays 80% of the allowed amount after a $162 deductible.	Pays the annual $162 deductible and the remaining 20% of Medicare's allowed charges.
Durable Medical Equipment	Pays 80% of the allowed amount after a $162 deductible.	Pays the annual $162 deductible and the remaining 20% of Medicare's allowed charges.
Mental Health	Pays 50% of the allowed amount after a $162 deductible	Pays the annual $162 deductible and the remaining 45% of Medicare's allowed charges.
Ambulance	80% of the allowed amount after a $162 deductible.	Pays the annual $162 deductible and the remaining 20% of Medicare's allowed charges.
*** Preventive services covered by Medicare**	Pays a percentage of the allowed amount after a $162 deductible.	Pays the remaining percentage of Medicare's approved amount.
Excess Charges (unassigned charges in excess of Medicare's allowed amount)	Pays nothing	Pays up to 115% of the Medicare allowable amount.

* No one can be enrolled (as a subscriber or dependent) in this product unless they are eligible for and enrolled in Medicare Parts A and B.

* For the most current information regarding your Medicare coverage visit www.medicare.gov on the web. Or, call 1-800-MEDICARE (1-800-633-4227).

Covered Services (Cont.)	Medicare Pays*	Blue Retiree Plan Pays*
Out-of-Hospital Skilled Private Duty Nursing, and Visiting Nurse's Association	Nothing	Pays 80% of covered charges after $162 Major Medical deductible. N/A maximum per calendar year.
Morbid Obesity	Nothing	Subject to contract deductible; pays 80% of covered charges.
WELLNESS RIDER:		
Physical Exams	Nothing	Not subject to deductible: pays remaining balance at 100% up to $150 per calendar year for all routine care exams.
Vision benefits	Nothing	Anthem Blue Vision Plan 1: Network Only Benefits Eye examination (1 every 12 months): $5 copayment Lenses (single vision, bifocal, trifocal, lenticular lenses) & Frames: 20% discount Prescription Contact Lenses: Professional Services: 15% discount Materials: Not Covered Laser Vision Correction Services: Discount available at participating Lasik/PRK surgical centers/

Major Medical Benefits

Covers inpatient hospital, skilled nursing facility claims and Home Health Care after Medicare's benefits have been exhausted. In addition the plan covers certain other services not covered by Medicare such as private duty nursing care, treatment of dental accidents, care outside the U.S.A., prescription drugs, and other Medicare eligible services that Anthem determines to be medically necessary and not experimental or investigational in nature. All services are covered subject to an annual deductible and percentage copayments.

Major Medical Options:

DEDUCTIBLE - Applies to Out of Pocket maximum ☒ $100 ☐ $200 ☐ $300 ☐ $400	
OUT-OF-POCKET MAXIMUM ☐ None ☒ $ 600 ☐ $1,000 ☐ $1,500 ☐ $2,000	
COPAYMENTS FOR COVERED SERVICES **See Covered Services for copayment information.** ☐ 10% Coinsurance Rate ☒ 20% Coinsurance Rate	
WELLNESS CARE RIDER: ☐ Yes ☒ No Includes coverage for physical exam ($150 per calendar year) and for dental and hearing services (annual maximum of $50 for each category) and for vision exam and discounted services for glasses and contact lenses.	
LIFETIME MAXIMUM ☐ $ 250,000 ☐ $ 500,000 ☒ $1,000,000	
Skilled Nursing Facility: ☐ 100 Days ☒ Unlimited	
PRESCRIPTION DRUGS OPTIONS	
Network/Anthem RX **Mail Service Pharmacy**	**Non-network Pharmacy**
☐ **Retail**: 40% Generic 50% Brand No Formulary **Mail Order**: (90 day supply) $15 Generic $35 Brand	**Retail:** 40% Generic 50% Brand No Formulary **Mail Order:** (90 day supply) $15 Generic $35 Brand
☒ No prescription benefit	

Prescription drug options assume a "wrap" option to Medicare Part D. Some groups are eligible for other options. Contact your Sales Representative for "waiver" or "subsidy" options.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date