

**State of Indiana
2015 Anthem/ESI Benefits**



	Wellness CDHP	CDHP 1	CDHP 2	Traditional PPO
Deductible				
<i>Single</i>	\$2,500 network/non-network	\$2,500 network/non-network	\$1,500 network/non-network	\$750 network/ \$1,500 non-network
<i>Family</i>	\$5,000 network/non-network	\$5,000 network/non-network	\$3,000 network/non-network	\$1,500 network/\$3,000 non-network
	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.			
Out-of-Pocket Maximum				
<i>Single</i>	\$4,000 network/non-network	\$4,000 network/non-network	\$3,000 network/non-network	\$3,000 network/\$6,000 non-network
<i>Family</i>	\$8,000 network/non-network	\$8,000 network/non-network	\$6,000 network/non-network	\$6,000 network/\$12,000 non-network
	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.			
	Note: 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.			
Professional Office Services including allergy - testing and treatment - serum and injections	20% network/ 40% non-network per visit	20% network/ 40% non-network per visit	20% network/ 40% non-network per visit	30% network/ 50% non-network per visit
Preventive Care Services Services include but are not limited to: Annual physical exams, pelvic exams, pap testing, routine mammograms, screening colorectal cancer exam, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing exams. All preventive services are limited to one of each service per year per covered member. 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.	Covered In Full network/ 40% non-network Both in-network and out-of-network are <u>not</u> subject to the deductible	Covered In Full network/ 40% non-network Both in-network and out-of-network are <u>not</u> subject to the deductible	Covered In Full network/ 40% non-network Both in-network and out-of-network are <u>not</u> subject to the deductible	Covered In Full network/ 50% non-network Both in-network and out-of-network are <u>not</u> subject to the deductible
Medical Supplies, Equipment & Appliances	20% network/ 40% non-network	20% network/ 40% non-network	20% network/ 40% non-network	30% network/ 50% non-network
Maternity Services	20% network/ 40% non-network	20% network/ 40% non-network	20% network/ 40% non-network	30% network/ 50% non-network
Inpatient Facility Services	20% network/ 40% non-network	20% network/ 40% non-network	20% network/ 40% non-network	30% network/ 50% non-network
Outpatient Facility Services	20% network/ 40% non-network	20% network/ 40% non-network	20% network/ 40% non-network	30% network/ 50% non-network
Professional Inpatient/Outpatient Services	20% network/ 40% non-network	20% network/ 40% non-network	20% network/ 40% non-network	30% network/ 50% non-network
Emergency (ER) and Urgent Care: - Emergency Care in ER - Urgent Care Facility	20% network/ 20% non-network	20% network/ 20% non-network	20% network/ 20% non-network	30% network/ 30% non-network
Ambulance	20% network/ 20% non-network	20% network/ 20% non-network	20% network/ 20% non-network	30% network/ 30% non-network
Outpatient Therapy Services (Combined network and non-network limits apply) - Physical therapy: 25 visits - Occupational therapy: 25 visits - Manipulation therapy: 12 visits - Speech therapy: 25 visits	20% network/ 40% non-network	20% network/ 40% non-network	20% network/ 40% non-network	30% network/ 50% non-network
Diabetes Self Management Training	20% network/ 40% non-network	20% network/ 40% non-network	20% network/ 40% non-network	30% network/ 50% non-network
Diagnostic Services (i.e. lab, x-ray, MRI)	20% network/ 40% non-network	20% network/ 40% non-network	20% network/ 40% non-network	30% network/ 50% non-network

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	Wellness CDHP	CDHP 1	CDHP 2	Traditional PPO				
Temporomandibular Joint (TMJ) Services - Outpatient facility - Provider individual - TMJ surgery - professional services - Private Duty Nursing limited to 82 visits/calendar year and 164 visits/lifetime	20% network/ 40% non-network	20% network/ 40% non-network	20% network/ 40% non-network	30% network/ 50% non-network				
Hospice	20% network/ 20% non-network	20% network/ 20% non-network	20% network/ 20% non-network	30% network/ 30% non-network				
Home Health Care No RN/LPN unless billed through a home health care agency	20% network/ 40% non-network	20% network/ 40% non-network	20% network/ 40% non-network	30% network/ 50% non-network				
Home IV Therapy	20% network/ 40% non-network	20% network/ 40% non-network	20% network/ 40% non-network	30% network/ 50% non-network				
Managed Mental Health including Substance Abuse 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	20% network/ 40% non-network	30% network/ 50% non-network				
Human Organ and Tissue Transplants (HOTT) Specialty Network See contract for other maximums/exclusions	20% network/ 40% non-network	20% network/ 40% non-network	20% network/ 40% non-network	30% network/ 50% non-network				
Prescription Drug Coverage (applies to all 4 plans) – THIS COVERAGE IS ADMINISTERED BY EXPRESS SCRIPTS (1) Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum								
	Retail (up to 30 days)	Mail (up to 90 days)	Retail (up to 30 days)	Mail (up to 90 days)	Retail (up to 30 days)	Mail (up to 90 days)	Retail (up to 30 days)	Mail (up to 90 days)
Preventive (mandated by the ACA)	\$0 (no deductible)	\$0 (no deductible)	\$0 (no deductible)	\$0 (no deductible)	\$0 (no deductible)	\$0 (no deductible)	\$0 (no deductible)	\$0 (no deductible)
Generic	\$10 copay	\$20 copay	\$10 copay	\$20 copay	\$10 copay	\$20 copay	\$20 copay	\$40 copay
Brand, Formulary	20% Min \$30, Max \$50	20% Min \$60, Max \$100	20% Min \$30, Max \$50	20% Min \$60, Max \$100	20% Min \$30, Max \$50	20% Min \$60, Max \$100	30% Min \$40, Max \$60	30% Min \$80, Max \$120
Brand, Non-Formulary	40% Min \$50, Max \$70	40% Min \$100, Max \$140	40% Min \$50, Max \$70	40% Min \$100, Max \$140	40% Min \$50, Max \$70	40% Min \$100, Max \$140	50% Min \$70, Max \$90	50% Min \$140, Max \$180
Specialty	40% Min \$75, Max \$150 (30 day supply)		40% Min \$75, Max \$150 (30 day supply)		40% Min \$75, Max \$150 (30 day supply)		50% Min \$100, Max \$175 (30 day supply)	

* Copays, coinsurance and deductible apply to out-of-pocket maximum

See Benefit Booklet for Exclusions

Notes:

- (1) 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: up to the last day of the month of the child's 26th 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 an 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 82 visits/calendar year and 164 visits/lifetime
- Skilled Nursing Facility: limited to 100 days
- Abortion coverage is limited to coverage in cases of rape or incest, or if it is necessary to avert the pregnant woman's death or irreversible impairment of a major bodily function.

Precertifications:

- Members are encourage 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.