

Open Enrollment 2012
 Compare Anthem PPO and HD Plan Summaries

| | PPO Plan | | HD/HSA Plan | |
|---|-------------------|-----------------|--|------------------|
| | Network | Non-Network | Network | Non-Network |
| Deductible | \$500/\$1,000 | \$1,000/\$2,000 | \$2,500/\$5,000 | \$2,500/\$5,000 |
| Out-of-Pocket Limit | \$2,000/\$4,000 | \$4,000/\$8,000 | \$3,500/\$7,000 | \$7,000/\$14,000 |
| Coinsurance | ded + 20% | ded + 40% | ded + 0% | ded + 30% |
| Physician Office Services (PCP/SCP) | | | | |
| office visit copay | \$25 PCP/\$50 SCP | ded + 40% | | |
| allergy injections | No Cost Share | ded + 40% | ded + 0% | ded + 30% |
| allergy testing | ded + 20% | ded + 40% | | |
| Diagnostic mammograms and pap testing (regardless of outpatient setting) | No Cost Share | ded + 40% | ded + 0% Preventative covered in full | ded + 30% |
| MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds | ded + 20% | ded + 40% | ded + 0% | ded + 30% |
| Preventive Care Services | | | | |
| Office Visits (PCP/SCP) | | | | |
| Other Outpatient Services @ Hospital/Alternative Care Facility | No Cost Share | ded + 40% | No Cost Share | ded + 30% |
| Emergency and Urgent Care | | | | |
| Emergency Room Visit | \$150 Copay | \$150 Copay | ded + 0% | ded + 0% |
| Urgent Care Visit | \$75 Copay | ded + 40% | | |
| allergy injections | \$5 Copay | ded + 40% | ded + 0% | ded + 30% |
| allergy testing | ded + 20% | ded + 40% | | |
| Inpatient and Outpatient Professional Services | | | | |
| Medical Care visits, Intensive Medical Care, concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams | ded + 20% | ded + 40% | ded + 0% | ded + 30% |

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|--|-------------------------------------|---|-------------------------------------|--|
| | Network | Non-Network | Network | Non-Network |
| Inpatient Facility Services | | | | |
| Unlimited days except for: 60 days Network/Non-network combined for | ded + 20% | ded + 40% | ded + 0% | ded + 30% |
| | 120 day benefit maximum for skilled | | 100 day benefit maximum for skilled | |
| Outpatient Surgery Hospital/Alternative Care Facility | | | | |
| Surgery and administration of general anesthesia | ded + 20% | ded + 40% | ded + 0% | ded + 30% |
| 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) 180 visits (excludes IV Therapy) Durable Medical Equipment and Orthotics Prosthetic Devices Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services | ded + 20% | ded + 40% (ded +20% for Hospice Care and Ambulance Services) | ded + 0% | ded + 30% (ded +0% for Hospice Care and Ambulance Services) |
| Outpatient Therapy Services (Combined Network & Non-network limits apply) | | | | |
| Physician Office Visits (PCP/SCP) | \$25/\$50 | ded + 40% | ded + 0% | ded + 30% |
| Other Outpatient Services @ Hospital/Alternative Care Facility | ded + 20% | ded + 40% | ded + 0% | ded + 30% |
| Cardiac Rehabilitation Visit Limit | 36 Visits | | 36 Visits | |
| Pulmonary Rehabilitation Visit Limit | 20 Visits | | 20 Visits | |
| Physical Therapy Visit Limit | No Limit | | 20 Visits | |
| Occupational Therapy Visit Limit | No Limit | | 20 Visits | |
| Manipulation Therapy Visit Limit | No Limit | | 12 Visits | |

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| | Network | Non-Network | Network | Non-Network |
| Outpatient Therapy Services (Combined Network & Non-network limits apply) | | | | |
| Speech Therapy Visit Limit | No Limit | | 20 Visits | |
| Mental Health and Substance Abuse | | | | |
| Inpatient Facility Services | ded + 20% | ded + 40% | ded + 0% | ded + 30% |
| Physician Office Visits (PCP/SCP) | \$25/\$25 | ded + 40% | | |
| Other Outpatient Services @ Hospital/Alternative Care Facility | ded + 20% | ded + 40% | | |
| Human Organ and Tissue Transplants | | | | |
| Acquisition and transplant procedures, harvest and storage | No Cost Share | ded + 50% | No Cost Share | ded + 30% |
| Prescription Drugs | Deductible does not need to be met before copays apply. Copays continue even after out-of-pocket max is met | | Rx copays begin after plan deductible is satisfied. Rx copays apply to out-of-pocket max. Prescriptions covered at 100% after OOP max is met. | |
| Network structure equals generic/brand formulary/brand non-formulary | | | | |
| Network Retail Pharmacies (30 Day Supply) Includes diabetic test strip | \$10/\$30/\$60 | 50%, min \$60 | \$10/\$30/\$50 Specialty 25%, max \$150 | 50%, min \$75 |
| Anthem Rx Direct Mail Service (Up to 90 Day Supply, Specialty up to 30 day Supply) Includes diabetic test strip | \$10/\$75/\$180 | Not Covered | \$10/\$75/\$150 Specialty 25%, max \$150 | Not Covered |
| Lifetime Maximum | Unlimited | | Unlimited | |

Notes:

coverage for other benefit details. In the event of a discrepancy, the Anthem documents prevail over this benefit exhibit.
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