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	Lowest Deductible CDHP	Medium Deductible CDHP	High Deductible CDHP	Maximum Deductible CDHP
Deductible *Single Family*	***Non-Embedded*** $1,750 Network/Non-Network $3,500 Network/Non-Network	***Embedded*** $3,200 Network/Non-Network $6,400 Network/Non-Network	***Embedded*** $3,850 Network/Non-Network $7,700 Network/Non-Network	***Embedded*** $4,750 Network/Non-Network $9,500 Network/Non-Network
Out-of-Pocket Maximum *Single Family*	***Non-Embedded*** $4,250 Network/$6,500 Non-Network $8,500 Network/$13,000 Non-Network *(Embedded at $7,500 max individual)*	***Embedded*** $4,500 Network/$7,000 Non-Network $9,000 Network/$14,000 Non-Network	***Embedded*** $5,500 Network/$8,000 Non-Network $11,000 Network/$16,000 Non-Network	***Embedded*** $7,500 Network/$10,000 Non-Network $15,000 Network/$20,000 Non-Network
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP) Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: * *allergy injections (PCP and SCP)* * *allergy testing* * *MRAs, MRIs, PETS, C-Scans, Nuclear* *Cardiology Imaging Studies, non maternity related Ultrasounds and pharmaceutical products*	20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network	20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network	20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network	20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network
Preventive Care Services Services included but not limited to: * *Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests,* *Immunizations, Annual diabetic* *eye exam, Hearing screenings and Vision screenings* *which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening*	No Costshare Network/30% Non-Network	No Costshare Network/30% Non-Network	No Costshare Network/30% Non-Network	No Costshare Network/30% Non-Network
Emergency and Urgent Care Emergency Room Services * *facility/other covered services* **Urgent Care Center Services** * *MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products* * *Allergy injections* * *Allergy testing*	20% Network/Non-Network 20% Network/30% Non-Network	20% Network/Non-Network 20% Network/30% Non-Network	20% Network/Non-Network 20% Network/30% Non-Network	20% Network/Non-Network 20% Network/30% Non-Network
Inpatient and Outpatient Professional Services Include, but are not limited to: * *Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams*	20% Network/30% Non-Network	20% Network/30% Non-Network	20% Network/30% Non-Network	20% Network/30% Non-Network

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Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: * *60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)* * *90 days for skilled nursing facility*	20% Network/30% Non-Network	20% Network/30% Non-Network	20% Network/30% Non-Network	20% Network/30% Non-Network
Outpatient Surgery Hospital/Alternative Care Facility * *Surgery and administration of general anesthesia*	20% Network/30% Non-Network	20% Network/30% Non-Network	20% Network/30% Non-Network	20% Network/30% Non-Network
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) 100 visits (excludes IV Therapy)* **Durable Medical Equipment and Orthotics* * *Prosthetic Devices* **Prosthetic Limbs* **Physical Medicine Therapy Day Rehabilitation programs* **Hospice Care* **Ambulance Services*	20% Network/30% Non-Network 20% Network/20% Non-Network 20% Network/20% Non-Network	20% Network/30% Non-Network 20% Network/20% Non-Network 20% Network/20% Non-Network	20% Network/30% Non-Network 20% Network/20% Non-Network 20% Network/20% Non-Network	20% Network/30% Non-Network 20% Network/20% Non-Network 20% Network/20% Non-Network
Outpatient Therapy Services *(Combined Network & Non-Network limits apply)* * *Physician Home and Office Visits (PCP/SCP)* * *Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to:* * *Physical therapy: 36 visits* * *Occupational therapy: 20 visits* * *Manipulation therapy: 24 visits* * *Speech therapy: 20 visits* * *Cardiac Rehabilitation: 36 visits* * *Pulmonary Rehabilitation: 20 visits*	20% Network/30% Non-Network 20% Network/30% Non-Network	20% Network/30% Non-Network 20% Network/30% Non-Network	20% Network/30% Non-Network 20% Network/30% Non-Network	20% Network/30% Non-Network 20% Network/30% Non-Network
Accidental Dental: No maximum	Copayments/Coinsurance based on setting where covered services are received 30% Non-Network	Copayments/Coinsurance based on setting where covered services are received 30% Non-Network	Copayments/Coinsurance based on setting where covered services are received 30% Non-Network	Copayments/Coinsurance based on setting where covered services are received 30% Non-Network

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Behavioral Health Services **Mental Illness and Substance Abuse**[1]**:** * *Inpatient Facility Services* * *Inpatient Professional Services* * *Physician Home and Office Visits (PCP/SCP)* * *Other Outpatient Services, Outpatient Facility @ Hospital / Alternative Care Facility, Outpatient Professional*	20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network	20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network	20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network	20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network 20% Network/30% Non-Network
Human Organ and Tissue Transplants[2] *Acquisition and transplant procedures, harvest and storage	20% Network/30% Non-Network	20% Network/30% Non-Network	20% Network/30% Non-Network	20% Network/30% Non-Network
Prescription Drug Options: Anthem National Drug List Network Tier structure equals 1/2/3 (and 4 if applicable) ***Network Retail Pharmacies:*** *(30-day supply)* *Includes diabetic test strip* ***Home Delivery Service:*** *(90-day supply)* *Includes diabetic test strip* *Member may be responsible for additional cost when not selecting the available generic drug.* **Medicare Rx - Wrap** **Specialty Medications** must be obtained via our Specialty Pharmacy network in order to receive network level benefits Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.	Tier 1 - 0% Network/Not covered Non-Network Tier 2 - 30% Network/Not covered Non-Network Tier 3 - 40% Network/Not covered Non-Network Tier 4 - 50% Network/Not covered Non-Network Tier 1 - 0% Network/Not covered Non-Network Tier 2 - 30% Network/Not covered Non-Network Tier 3 - 40% Network/Not covered Non-Network Tier 4 - 50% Network/Not covered Non-Network	Tier 1 - 0% Network/Not covered Non-Network Tier 2 - 30% Network/Not covered Non-Network Tier 3 - 40% Network/Not covered Non-Network Tier 4 - 50% Network/Not covered Non-Network Tier 1 - 0% Network/Not covered Non-Network Tier 2 - 30% Network/Not covered Non-Network Tier 3 - 40% Network/Not covered Non-Network Tier 4 - 50% Network/Not covered Non-Network	Tier 1 - 0% Network/Not covered Non-Network Tier 2 - 30% Network/Not covered Non-Network Tier 3 - 40% Network/Not covered Non-Network Tier 4 - 50% Network/Not covered Non-Network Tier 1 - 0% Network/Not covered Non-Network Tier 2 - 30% Network/Not covered Non-Network Tier 3 - 40% Network/Not covered Non-Network Tier 4 - 50% Network/Not covered Non-Network	Tier 1 - 0% Network/Not covered Non-Network Tier 2 - 30% Network/Not covered Non-Network Tier 3 - 40% Network/Not covered Non-Network Tier 4 - 50% Network/Not covered Non-Network Tier 1 - 0% Network/Not covered Non-Network Tier 2 - 30% Network/Not covered Non-Network Tier 3 - 40% Network/Not covered Non-Network Tier 4 - 50% Network/Not covered Non-Network
Lifetime Maximum * *Medical* * *Surgical Treatment of Morbid Obesity*	Unlimited Not covered	Unlimited Not covered	Unlimited Not covered	Unlimited Not covered

Notes:

*All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services)

*Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment and coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.

*Dependent Age: to the end of the month in which the child attains age 26.

*Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.

*When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections.

*NCS (No Cost Share) means no deductible/copayment/coinsurance up to the maximum allowable amount.

*PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.

*SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

*Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.

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*Benefit period = Calendar Year
*Prosthetic limbs are unlimited and do not apply to the Plan Lifetime Maximum.
*Mammograms (Diagnostic) are no copayment/coinsurance in Network office and outpatient facility settings.
*Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
*Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
*Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
*Abortion coverage is limited to coverage in cases of rape or incest, or if it is necessary to avert the pregnant women's death or irreversible impairment of a major bodily function.
*Live Health Online (LHO) is covered at the PCP costshare.
1 These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.
2 We encourage you to review the Schedule of Benefits for limitations.
3 Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

Precertification:

Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

Pre-existing Exclusion Period: none

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.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

This benefit overview is for illustrative purposes and some content may be pending Indiana Department of Insurance approval.